

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01342

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		d. STREET ADDRESS <u>165 E Main St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Samuel Dean Albright</u>		4. DATE OF DEATH <u>Feb 23 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 17 1958</u>
9. AGE (In years last birthday) <u>11</u> yrs. <u>6</u> mos. <u>16</u> days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Nelson Albright Jr</u>		14. MOTHER'S MAIDEN NAME <u>Shelby Jean Garlock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Nelson Albright Jr</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Tracheo-Bronchitis</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Dehydration, Terminal</u> (a), stating the underlying cause last. DUE TO (c) <u>Aspiration of Stomach Contents</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10h</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Ashby Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Ashby, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>FEB 25 '59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>2/16/59</b>		d. STREET ADDRESS <b>223 Virginia Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clymer</b> Middle <b>K.</b> Last <b>Alderton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/ 9/1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Proprietor of Restaurant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland, Oldtown</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Alderton</b>		14. MOTHER'S MAIDEN NAME <b>Lavina Kifer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>		18. <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X Pulmonary Hypostasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Insufficiency</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/16/59</b> , 19___, to <b>2/28/59</b> , 19___, that I last saw the deceased alive on <b>2/28/59</b> , 19___, and that death occurred at <b>4:35 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>3/2/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1342

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>15 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>104 SOUTH STREET</b>							
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>L.</b> Last <b>ARBOGAST</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 7, 1876</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Blacksmith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. RR.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>ISAAC ARBOGAST</b>				14. MOTHER'S MAIDEN NAME <b>RACHEL DUCKWORTH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>D-220023</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephritis, Anemia secondary</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4-5-1958</b> to <b>2-6-1959</b> , that I last saw the deceased alive on <b>2-5-1959</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Howard L. Tolson</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>2-6-59</b>			
PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 9 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>				ADDRESS <b>Cumberland Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Don. J. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint, illegible text]</p>		<p>AGE                  [Faint, illegible text]</p>	
<p>SEX                  [Faint, illegible text]</p>		<p>RACE                  [Faint, illegible text]</p>	
<p>DATE OF BIRTH                  [Faint, illegible text]</p>		<p>DATE OF DEATH                  [Faint, illegible text]</p>	
<p>PLACE OF BIRTH                  [Faint, illegible text]</p>		<p>PLACE OF DEATH                  [Faint, illegible text]</p>	
<p>CAUSE OF DEATH                  [Faint, illegible text]</p>		<p>MANNER OF DEATH                  [Faint, illegible text]</p>	
<p>SIGNATURE OF PHYSICIAN                  [Faint, illegible text]</p>		<p>SIGNATURE OF REGISTRAR                  [Faint, illegible text]</p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01345

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>225 Cecelia Street</b>	
3. NAME OF DECEASED (Type or print) <b>Clyde</b>		4. DATE OF DEATH <b>Feb. 11, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1906</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Instrument Repairman</b>	
11. BIRTHPLACE (State or foreign country) <b>Saxton, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Babst</b>		14. MOTHER'S MAIDEN NAME <b>Laura Sheetrum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>214-07-3493</b>	
17. INFORMANT <b>Mrs. Frances Babst</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of Stomach Contents</b> DUE TO (c) <b>Cerebral Edema; Internal Hydrocephalus</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cumberland</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Feb. 11, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	







1391

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Bean</b> Last <b>Bean</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1st</b> , Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23rd, 1910</b>
9. AGE (In years lost, birthday) <b>48</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Peoples Trans.Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Maurice Bean</b>	
14. MOTHER'S MAIDEN NAME <b>Nellie Hershberger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-01-7495</b>		17. INFORMANT <b>Mrs. Eleanor Bean, RD 2, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> 151X DUE TO (b) <b>18 mos.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>58</b> , to <b>FEB. 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>FEB. 1</b> , 19 <b>59</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED ACTUAL SIGNATURE <b>Martin M. Rothstein, M.D.</b> PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein, M.D.</b> <b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1391

Allegany

Maryland

Allegany

From Church

Life Insurance Co. of Baltimore

Edwards

Boon

Boon

Male

White

June 27th, 1910

Age

Bus Driver

People's Trust Co.

Baltimore

MD

Martin Bean

William H. H. H. H.

312-01-0105 Mrs. Eleanor K. R. S. Strobbe, Md.

Martin M. H. H. H.

Providence

MD

2-1-50

Providence

Providence

MD

Joseph H. H. H.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01347

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Smith Apts. Kelly Blvd.</b>			d. STREET ADDRESS <b>Smith Apts. Kelly Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Emery</b> Middle <b>Clay</b> Last <b>Bennett</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>18,</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1893</b>		9. AGE (In years last birthday) <b>65</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rugs, Blind Weavers</b>		11. BIRTHPLACE (State or foreign country) <b>Flintstone, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>George Bennett</b>			14. MOTHER'S MAIDEN NAME <b>Jemima Leasure</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes, W.W.# 1</b>		16. SOCIAL SECURITY NO. <b>286-07-7707</b>		17. INFORMANT <b>Mrs. Walter Smith, Smith Apts, Cumb.Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary sclerosis</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>(County)</b> (State)		
21. I certify that I took charge of the remains described above, held on <del>XXXXXX</del> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Feb. 18, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/20/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Artemis, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>



STATE OF TEXAS  
COUNTY OF DALLAS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF TEXAS

Form with multiple sections for medical examination and death certification, including checkboxes and fields for medical history, physical examination, and cause of death.

1. I, the undersigned, being a duly qualified Medical Examiner of the State of Texas, do hereby certify that the above named person died on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, \_\_\_\_\_, State of Texas.

2. The death was caused by \_\_\_\_\_

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## CERTIFICATE OF DEATH

01348

Reg. Dist. No.

1345

1. PLACE OF DEATH COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>HAMPSHIRE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPRINGFIELD, W.VA.</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>MEMORIAL AVE.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>J.</b> Last <b>BLUE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885 AUG. 29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.VA.</b>	9. AGE (In years lost (in thoy) yrs.) <b>73</b>
13. FATHER'S NAME <b>JAMES BLUE</b>		14. MOTHER'S MAIDEN NAME <b>SARA WASHINGTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 yr.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Feb</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 9</b> , 19 <b>59</b> , and that death occurred at <b>4:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G O Himmie Wright</b>		ADDRESS (Street, city or town, state) <b>133 Va Ave, Cumberland, Md</b>	
PHYSICIAN'S NAME (Type) <b>G O Himmie Wright</b>		DATE SIGNED <b>2/11/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Indian Mound</b>	22d. LOCATION (City, town, or county) (State) <b>Romney W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seith Shaffer</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 16 '59</b>	
ADDRESS <b>Romney W.Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1922

DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01349

Reg. Dist. No.

1346

Item # 7 - Film 239 - 2/7/59 - mbs

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rawlings,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Sacred Heart Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Martin Bobo</b>		4. DATE OF DEATH Month Day Year <b>Feb. 25 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Dawson, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bobo</b>		14. MOTHER'S MAIDEN NAME <b>Susan Dawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-6139</b>	
17. INFORMANT <b>Mrs. Ethel S. Bobo Rawlings, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Feb. 25, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Waxler Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rawlings, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1347

## CERTIFICATE OF DEATH

01350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>20 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgeley</b> d. STREET ADDRESS <b>1 Second Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edgar Bootman</b>		4. DATE OF DEATH Month Day Year <b>Feb. 8 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/04</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. Liquor Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Va. State Store</b>	9. AGE (In years last birthday) yrs. <b>54</b> 11. BIRTHPLACE (State or foreign country) <b>West Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Thomas A. Bootman</b>		14. MOTHER'S MAIDEN NAME <b>Clara M. Bancord</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>234-38-7920</b>	
17. INFORMANT <b>Mrs. Louise Bootman</b>		Address <b>Ridgeley, W. Va. 1 Second Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer with stenosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-1-59</b> , to <b>2-7-59</b> , that I last saw the deceased alive on <b>2-6-59</b> , and that death occurred at <b>5:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St., Cumberland, Md.</b> DATE SIGNED <b>2-7-59</b>			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		M.D. <b>62 Greene St., Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>FEB 13 '59</b>
		24b. REGISTRAR'S SIGNATURE <i>Arthur E. H. H. H.</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01351

1406

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Cresaptown</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 5, Cumberland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural, Cresaptown</b>	
3. NAME OF DECEASED (Type or print) <b>EDISON</b> First <b>SANFORD</b> Middle <b>BOWMAN</b> Last		4. DATE OF DEATH <b>February 7</b> Month <b>7</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Boynton, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Chauncey Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Chorpenning</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-07-5410</b>	
17. INFORMANT <b>Mrs. Olive Bowman</b>		Address <b>Rt. 5, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb 4, 1959</b> , to <b>Feb 7, 1959</b> , that I last saw the deceased alive on <b>Feb 4, 1959</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Womc Lane</b>		DATE SIGNED <b>Feb 9 1959</b>	
PHYSICIAN'S NAME (Type) <b>Womc Lane</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Pennsylvania</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>100th Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 11 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01352

## CERTIFICATE OF DEATH

Reg. Dist. No.

1348

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOMER</b> Middle <b>B</b> Last <b>BRILL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 25, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>KIRBY, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BRILL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH SAVILLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW 1 214 05 9480</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Metastasis from</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of lung removed 8 mos.</b> DUE TO <b>7-17-58</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-21-1958</b> to <b>2-25-1959</b> , that I last saw the deceased alive on <b>2-25-1959</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. F. Williams</b> <b>Cumberland Md</b> <b>2/26/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/28/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>MAR 2 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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1455

STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

RESIDENT IN

ALLEGANY

DECEASED

DATE OF DEATH

DAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01353

1349

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.,</b>		e. STREET ADDRESS <b>OLDTOWN</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>H</b> Last <b>CAGE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 1, 1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orchard Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruit Orchard</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES W. CAGE</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-09-7683</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>58</b> , to <b>Feb</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 2</b> , 19 <b>59</b> , and that death occurred at <b>10:15AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Va Ave Cumberland, Md</b> DATE SIGNED <b>2/3/59</b>			
ACTUAL SIGNATURE <b>G. OVERTON HIMMELWRIGHT</b>		M.D. <b>133 Va Ave Cumberland, Md</b>	
PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oliver Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Near Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01354

Reg. Dist. No.

1350

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>14 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>1 23 VIRGINIA AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>STELLA H. CASKEY</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 24 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 23 02</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MARTINSBURG, W. VA.</b>
13. FATHER'S NAME <b>HARRISON RUSSE</b>		14. MOTHER'S MAIDEN NAME <b>ANGELICA FREEZE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary emboli with infarction, multiple</b> DUE TO (c) <b>arteriosclerotic Heart Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>21 Feb. 1959</b> , to <b>24 Feb. 1959</b> , that I last saw the deceased alive on <b>24 Feb 59</b> , 19____, and that death occurred at <b>1:16 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b>		ADDRESS (Street, city or town, state) <b>122 S. Centre St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. ALFRED VAN ORMER</b> <b>DR. X GEORGE X SIMONS X</b>		DATE SIGNED <b>26 Feb. 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-28-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Martinsburg, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 2 59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



—Yakovlev

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1351  
CERTIFICATE OF DEATH

01355

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                   |                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                         | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |                                                   |                                                                                                   |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                             |                                         | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>                                                                                                    |                                                   |                                                                                                   |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL &amp; WARWICK AVES.</b>                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             |                                         | d. STREET ADDRESS<br><b>331 DORN AVE.</b>                                                                                                   |                                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LILLIAM</b> Middle <b>LOUISE</b> Last <b>CHALKLEY</b>                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                             |                                         | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>8</b> Year <b>19 59</b>                                                                        |                                                   |                                                                                                   |                                                                                                   |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCT. 8, 1895</b> |                                                                                                                                             | 9. AGE (In years last birthday)<br><b>63</b> yrs. | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                                                     |                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                                                        |                                         | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>                                                                          |                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                        |                                                                                                   |
| 13. FATHER'S NAME<br><b>KARL REIBERT</b>                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                         | 14. MOTHER'S MAIDEN NAME<br><b>LIZZIE NEWMAN</b>                                                                                            |                                                   |                                                                                                   |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                            |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |                                         | 17. INFORMANT<br><b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>                                                                                   |                                                   |                                                                                                   |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>260X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>Diabetes Mellitus</b> |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                   | INTERVAL BETWEEN ONSET AND DEATH                                                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                  |                                                                                                                                                             |                                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                |                                                   |                                                                                                   |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                      |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                                   |                                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                      |                                                   | 20f. (City or town) (County) (State)                                                              |                                                                                                   |
| 21. I certify that I attended the deceased from <b>June 1955</b> , to <b>Feb 6 1959</b> , that I last saw the deceased alive on <b>Feb 6 1959</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.                                                                                                                                     |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                   |                                                                                                   |
| ACTUAL SIGNATURE <b>George M. Simons</b> M.D.                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                         | ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>2/8/59</b>                                                        |                                                   |                                                                                                   |                                                                                                   |
| PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b>                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                   |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                 |                                  | 22b. DATE THEREOF<br><b>2-9-59</b>                                                                                                                          |                                         | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>                                                                           |                                                   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                      |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scapelli</b>                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                         | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                           |                                                   | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 10 59</b>                                                  |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             |                                         | 24b. REGISTRAR'S SIGNATURE<br><b>C. L. H. H.</b>                                                                                            |                                                   |                                                                                                   |                                                                                                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DECEASED  
NAME  
DATE OF DEATH

WILLIAM R. BROWN

|                         |  |                              |  |
|-------------------------|--|------------------------------|--|
| Name of Deceased        |  | Date of Death                |  |
| Age                     |  | Sex                          |  |
| Place of Birth          |  | Usual Residence              |  |
| Cause of Death          |  | Manner of Death              |  |
| Physician's Signature   |  | Medical Examiner's Signature |  |
| Date of Report          |  | Time of Report               |  |
| Signature of Registrar  |  | Signature of Coroner         |  |
| Signature of Undertaker |  | Signature of Burial Place    |  |
| Signature of Family     |  | Signature of Friends         |  |
| Signature of Church     |  | Signature of Community       |  |
| Signature of State      |  | Signature of Nation          |  |





1352

# CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                                   |  |                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>o. COUNTY                                                                                                                                                                                                                                   |  | MARYLAND                                                                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE                                                           |  | Maryland                                                                                                  |  | b. COUNTY                                                                                         |  | Allegany                                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cumberland                                                                                                                                                                   |  | c. LENGTH OF STAY IN lb<br>7 days                                                            |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>02 Cumberland, Maryland                                                 |  | d. STREET ADDRESS<br>107 Valley Street                                                                    |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                        |  |
| 3. NAME OF DECEASED<br>(Type or print)                                                                                                                                                                                                                           |  | First<br>Charles                                                                             |  | Middle<br>E.                                                                                                                                                |  | Last<br>Darber                                                                                            |  | 4. DATE OF DEATH<br>Month<br>February                                                             |  | Day<br>25th                                            |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                   |  | 6. COLOR OR RACE<br>White                                                                    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>5-21-1879 1878                                                                        |  | 9. AGE (In years last birthday)<br>80 yrs.                                                        |  | 10. IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Salesman                                                                                                                                                          |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Wholesale Produce                                       |  | 11. BIRTHPLACE (State or foreign country)<br>West Virginia                                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                    |  |                                                                                                   |  |                                                        |  |
| 13. FATHER'S NAME<br>Frederick Darber (D)                                                                                                                                                                                                                        |  | 14. MOTHER'S MAIDEN NAME<br>Flagg Virginia                                                   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)                                                                                       |  | 16. SOCIAL SECURITY NO.<br>214-05-574                                                                     |  | 17. INFORMANT<br>Chart Pt's                                                                       |  | Address                                                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c) |  | Coronary Occlusion                                                                           |  | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                            |  |                                                                                                           |  |                                                                                                   |  |                                                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                |  |                                                                                              |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                      |  |                                                                                                           |  |                                                                                                   |  |                                                        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.                                                                                                                  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  | 20f. (City or town)<br>(County)<br>(State)             |  |
| 21. I certify that I attended the deceased from 7/18, 1959, to 7/25, 1959, that I last saw the deceased alive on 7/25, 1959, and that death occurred at 3:00 P. M., from the causes and on the date stated above.                                                |  | ADDRESS (Street, city or town, state)                                                        |  | DATE SIGNED<br>7/27/59                                                                                                                                      |  |                                                                                                           |  |                                                                                                   |  |                                                        |  |
| ACTUAL SIGNATURE<br>L. H. Ley Jr.                                                                                                                                                                                                                                |  | M.D.                                                                                         |  | PHYSICIAN'S NAME (Type)<br>Dr. L. H. Ley                                                                                                                    |  | 456 North Centre Street, Cumberland Md.                                                                   |  |                                                                                                   |  |                                                        |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                              |  | 22b. DATE THEREOF<br>2/28/59                                                                 |  | 22c. NAME OF CEMETERY OR CREMATORY<br>St. Peter & Paul Cemetery                                                                                             |  | 22d. LOCATION (City, town, or county)<br>Cumberland                                                       |  | (State)<br>md.                                                                                    |  |                                                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Louis Stein, Inc.                                                                                                                                                                                                            |  | ADDRESS<br>Cumberland, Md.                                                                   |  | 24a. REC'D BY REGISTRAR<br>DATE<br>MAR 3 '59                                                                                                                |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Hines                                                             |  |                                                                                                   |  |                                                        |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
ISM 10/57



100



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1353

## CERTIFICATE OF DEATH

01357

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b><br>MARYLAND                                                                                                                                                                                                                                                                                                        |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Allegany</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                             |                                  | c. LENGTH OF STAY IN lb<br><b>6/20/55</b>                                                                                                                   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>                                                                                                                                                                                                                                                  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rose</b> Middle <b>S.</b> Last <b>Dawson</b>                                                                                                                                                                                                                                                                      |                                  | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>12</b> Year <b>19 59</b>                                                                                   |                                      |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                           | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/1/1873</b> |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.                                                                                                                                                                                                                                                                                                                 |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                               |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Barton, Maryland</b>                                                                                                                                                                                                                                                                                              |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                             |                                      |
| 13. FATHER'S NAME<br><b>Frederick Shuhart</b>                                                                                                                                                                                                                                                                                                                     |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Burkett</b>                                                                                                             |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                                                                                                                |                                  | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service)                                                                                             |                                      |
| 17. INFORMANT <b>P.O.Box 599</b><br><b>Allegany County Infirmary Records</b>                                                                                                                                                                                                                                                                                      |                                  | Address <b>Cumberland, Md.</b>                                                                                                                              |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Chronic Myocardial Degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b><br>(c) <b>Chronic nephritis</b> |                                  |                                                                                                                                                             |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b>                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                            |                                  | 20f. (City or town) (County) (State)                                                                                                                        |                                      |
| 21. I certify that I attended the deceased from <b>6/20/55</b> , 19____, to <b>2/12/59</b> , 19____, that I last saw the deceased alive on <b>2/11/59</b> , 19____, and that death occurred at <b>2:00P</b> M, from the causes and on the date stated above.                                                                                                      |                                  |                                                                                                                                                             |                                      |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.                                                                                                                                                                                                                                                                                                                      |                                  | ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>2/12/59</b>                                                                       |                                      |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>                                                                                                                                                                                                                                                                                                                |                                  | <b>Cumberland, Maryland</b>                                                                                                                                 |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                        |                                  | 22b. DATE THEREOF<br><b>2/15/59</b>                                                                                                                         |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laydel Hill</b>                                                                                                                                                                                                                                                                                                          |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow Mills Md.</b>                                                                                    |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. L. Boul - Westernport, Md.</b>                                                                                                                                                                                                                                                                                          |                                  | 24a. REC'D BY REGISTRAR<br><b>FEB 16 '59</b>                                                                                                                |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1923

|                  |  |                |  |                |  |                 |  |                      |  |                       |  |
|------------------|--|----------------|--|----------------|--|-----------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX            |  | RACE            |  | DATE OF DEATH        |  | PLACE OF DEATH        |  |
| JAMES H. HARRIS  |  | 45             |  | Male           |  | White           |  | 1923                 |  | Baltimore, Md.        |  |
| RESIDENCE        |  | OCCUPATION     |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | CERTIFICATE OF DEATH |  | SIGNATURE OF DECEASED |  |
| 1234 N. Main St. |  | Carpenter      |  | Heart Disease  |  | Natural         |  | 1923                 |  | J. H. Harris          |  |
| DATE OF BIRTH    |  | PLACE OF BIRTH |  | EDUCATION      |  | MARRIAGE        |  | SIGNED BY            |  | DATE                  |  |
| 1878             |  | Maryland       |  | High School    |  | Married         |  | J. H. Harris         |  | 1923                  |  |
| DATE OF DEATH    |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | CERTIFICATE OF DEATH |  | SIGNATURE OF DECEASED |  |
| 1923             |  | Baltimore, Md. |  | Heart Disease  |  | Natural         |  | 1923                 |  | J. H. Harris          |  |
| DATE OF BIRTH    |  | PLACE OF BIRTH |  | EDUCATION      |  | MARRIAGE        |  | SIGNED BY            |  | DATE                  |  |
| 1878             |  | Maryland       |  | High School    |  | Married         |  | J. H. Harris         |  | 1923                  |  |





1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1354

CERTIFICATE OF DEATH

01358

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                            |                                                                                                                                                             |                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>             |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                            | c. LENGTH OF STAY IN Ib<br><b>16 DAYS</b>                                                                                                                   |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                            | e. STREET ADDRESS<br><b>ROUTE # 1</b>                                                                                                                       |                                                                                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARLEY</b> Middle <b>BENJAMIN</b> Last <b>DAY</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            | 4. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>6</b> Year <b>19 59</b>                                                                                    |                                                                                                   |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. COLOR OR RACE<br><b>WHITE</b>                                                                                           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 25, 1890</b>                                                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED Machinist</b>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Rwy. Machinist</b>                                                                                                  |                                                                                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                                                   |
| 13. FATHER'S NAME<br><b>MILES DAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                            | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE BLAIR</b>                                                                                                              |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                            | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                                                                                   |
| 17. INFORMANT<br><b>WARWICK &amp; MEMORIAL AVE. MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            |                                                                                                                                                             |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>multiple Obsessed Lungs</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma left lung</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                                                                                                            |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>2 years</b>                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                      |                                                                                                                            |                                                                                                                                                             | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                            |                                                                                                                                                             |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town) (County) (State)                                                              |
| 21. I certify that I attended the deceased from <b>May</b> , 19 <b>58</b> , to <b>Feb 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 5</b> , 19 <b>59</b> , and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.                                                                                                                                                                                                              |                                                                                                                            |                                                                                                                                                             |                                                                                                   |
| ACTUAL SIGNATURE <b>Dr. Weisman</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                            | ADDRESS (Street, city or town, state) <b>57 Greene St Cumberland Md</b>                                                                                     |                                                                                                   |
| PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            | DATE SIGNED <b>2/7/59</b>                                                                                                                                   |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | 22b. DATE THEREOF<br><b>Feb. 8, 1959</b>                                                                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Ashby Cemetery</b>                                                                                            | 22d. LOCATION (City, town, or county) (State)<br><b>Fort Ashby, W. Va.</b>                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George, Cumberland, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                            | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 10 '59</b>                                                                                                           | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Frank</b>                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1355

## CERTIFICATE OF DEATH

01359

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |                                                                                                          |                                                                                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                          |                                  | c. LENGTH OF STAY IN 1b<br><b>35yrs.</b>                                                                                                                    |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |                                                                                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>735 Maryland, Ave.</b>                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                             | d. STREET ADDRESS<br><b>735 Maryland, Ave.</b>                                                                                              |                                                                                                          | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OPAL</b> Middle <b>LAVODA</b> Last <b>DICKINSON</b>                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>10</b> Year <b>19 59</b>                                                                       |                                                                                                          |                                                                                                |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                        | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/21/14</b>                                                                                                          |                                                                                                          | 9. AGE (In years last birthday)<br><b>44</b> yrs. Months Days Hours Min.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeper at Home</b>                                                                                                                                                                                                                                      |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>                                               |                                                                                                |
| 13. FATHER'S NAME<br><b>James S. Thomas</b>                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                                                                          |                                                                                                |
| 14. MOTHER'S MAIDEN NAME<br><b>Laura Wagoner</b>                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>                                                                |                                                                                                          |                                                                                                |
| 16. SOCIAL SECURITY NO.<br><b>none</b>                                                                                                                                                                                                                                                                                                                         |                                  | 17. INFORMANT Address<br><b>A. J. Dickinson Cumberland, Md.</b>                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>massive Cerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b><br>DUE TO (c)                                       |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b>                                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                          |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                                                             |                                                                                                          |                                                                                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                                                                                                                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |                                                                                                |
| 20f. (City or town)                                                                                                                                                                                                                                                                                                                                            |                                  | (County)                                                                                                                                                    |                                                                                                                                             | (State)                                                                                                  |                                                                                                |
| 21. I certify that I attended the deceased from <b>Sept. 15, 19 58</b> to <b>Feb 10, 19 59</b> , that I last saw the deceased alive on <b>Feb. 9, 19 59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>236 W. Con Cumberland</b> DATE SIGNED <b>Clayton L. Lurrett</b> |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
| ACTUAL SIGNATURE <b>Clayton L. Lurrett</b> M.D. <b>236 W. Con Cumberland</b>                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
| PHYSICIAN'S NAME (Type) _____                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                     |                                  | 22b. DATE THEREOF<br><b>2/12/59</b>                                                                                                                         |                                                                                                                                             | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Pk.</b>                                         |                                                                                                |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Md.</b>                                                                                                                                                                                                                                                                                                |                                  | (State)                                                                                                                                                     |                                                                                                                                             |                                                                                                          |                                                                                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Lee Silcox</b>                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br><b>Feb 16 59</b>                                                                                                 |                                                                                                          |                                                                                                |
| ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>                                                                                       |                                                                                                          |                                                                                                |







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1356

## CERTIFICATE OF DEATH

01360

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|---------------------------------------|--|----------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>                                                                                                                                                                                                                                                      |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>     |  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>                                                                                                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>WEST VIRGINIA</b> |  | b. COUNTY<br><b>PAW PAW</b>                                 |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PAW PAW</b> |  | d. STREET ADDRESS<br><b>85X-3</b>     |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>JOHN</b>                                                                                                                                                                                                                                            |  | Middle<br><b>B.</b>                                                                                       |  | Last<br><b>DOYLE</b>                                                                                                                                        |  | 4. DATE OF DEATH<br>Month<br><b>FEBRUARY</b>                                                                              |  | Day<br><b>26</b>                                            |  | Year<br><b>19 59.</b>                                                                              |  |                                       |  |                                                                                        |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                  |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>AUGUST 27, 1907</b>                                                                                |  | 9. AGE (In years last birthday)<br><b>51</b> yrs.           |  | IF UNDER 1 YEAR<br>Months<br><b>51</b>                                                             |  | IF UNDER 24 HRS.<br>Days<br><b>51</b> |  | Hours<br><b>51</b>                                                                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                            |  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><b>PAW PAW, W. VA.</b>                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| 13. FATHER'S NAME<br><b>JOHN DOYLE</b>                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME<br><b>REBECCA POST</b>                                                           |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)                                                |  | 16. SOCIAL SECURITY NO.                                                                                                   |  | 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> |  | Address                                                                                            |  |                                       |  |                                                                                        |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                                                          |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                      |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>                                                                                                                                                                                                                            |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      |  | 20f. (City or town)<br><b>PAW PAW</b>                                                                                     |  | (County)<br><b>W. VA.</b>                                   |  | (State)<br><b>W. VA.</b>                                                                           |  |                                       |  |                                                                                        |  |
| 21. I certify that I attended the deceased from <b>2. 25</b> , 19 <b>59</b> to <b>2. 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2. 26</b> , 19 <b>59</b> , and that death occurred at <b>1:25 P. M.</b> from the causes and on the date stated above.                            |  | ADDRESS (Street, city or town, state)<br><b>Cumberland Md</b>                                             |  | DATE SIGNED<br><b>2/27/59</b>                                                                                                                               |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| ACTUAL SIGNATURE<br><b>W. F. Williams</b>                                                                                                                                                                                                                                                              |  | M.D.<br><b>Cumberland Md</b>                                                                              |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. W. F. WILLIAMS</b>                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                           |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                             |  | 22b. DATE THEREOF<br><b>3/1/59</b>                                                                        |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>CAMP HILL</b>                                                                                                      |  | 22d. LOCATION (City, town, or county)<br><b>PAW PAW</b>                                                                   |  | (State)<br><b>W. VA.</b>                                    |  |                                                                                                    |  |                                       |  |                                                                                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. E. Johnson</b>                                                                                                                                                                                                                                               |  | ADDRESS<br><b>Berkeley Springs W. Va.</b>                                                                 |  | 24a. REC'D BY REGISTRAR<br><b>MAR 2 '59</b>                                                                                                                 |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Harris</b>                                                                     |  |                                                             |  |                                                                                                    |  |                                       |  |                                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 10/57



CERTIFICATE OF DEATH

1930

|                        |  |                        |  |                    |  |                      |  |                       |  |                          |  |                              |  |                           |  |                    |  |
|------------------------|--|------------------------|--|--------------------|--|----------------------|--|-----------------------|--|--------------------------|--|------------------------------|--|---------------------------|--|--------------------|--|
| NAME OF DECEASED       |  | AGE                    |  | SEX                |  | RACE                 |  | DATE OF BIRTH         |  | PLACE OF BIRTH           |  | CITY                         |  | COUNTY                    |  | STATE              |  |
| JAMES H. HARRIS        |  | 45                     |  | M                  |  | W                    |  | 1885                  |  | BALTIMORE                |  | BALTIMORE                    |  | BALTIMORE                 |  | MD                 |  |
| OCCUPATION             |  | CAUSE OF DEATH         |  | MANNER OF DEATH    |  | PERIOD OF ILLNESS    |  | DATE OF DEATH         |  | PLACE OF DEATH           |  | CITY                         |  | COUNTY                    |  | STATE              |  |
| LABORER                |  | HEART DISEASE          |  | NATURAL            |  | 2 WEEKS              |  | JANUARY 10, 1930      |  | BALTIMORE                |  | BALTIMORE                    |  | BALTIMORE                 |  | MD                 |  |
| FATHER'S NAME          |  | MOTHER'S NAME          |  | SPOUSE'S NAME      |  | CHILDREN             |  | EDUCATION             |  | RELIGION                 |  | POLITICAL PARTY              |  | MILITARY SERVICE          |  | OTHER NOTES        |  |
| JAMES H. HARRIS        |  | MARY H. HARRIS         |  | JANE H. HARRIS     |  | 2                    |  | HIGH SCHOOL           |  | METHODIST                |  | DEMOCRAT                     |  | NONE                      |  | NONE               |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF CLERK |  | SIGNATURE OF WITNESS |  | SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF BURIAL OFFICIAL |  | SIGNATURE OF FUNERAL HOME |  | SIGNATURE OF OTHER |  |
| J. H. HARRIS           |  | J. H. HARRIS           |  | J. H. HARRIS       |  | J. H. HARRIS         |  | J. H. HARRIS          |  | J. H. HARRIS             |  | J. H. HARRIS                 |  | J. H. HARRIS              |  | J. H. HARRIS       |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 3-2-59 et

## CERTIFICATE OF DEATH

01361

Reg. Dist. No.

1392

|                                                                                                                                                                                                                                                                                                                                                 |                                       |                                                                                                                                                             |                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Allegany</b><br>MARYLAND                                                                                                                                                                                                                                                                                   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Allegany</b>        |                                                                        |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                            |                                       | c. LENGTH OF STAY IN 1b<br><b>1 week</b>                                                                                                                    |                                                                        |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Private home</b>                                                                                                                                                                                                                                             |                                       | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                           |                                                                        |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>BENJAMIN</b><br>Middle<br><b>C.</b><br>Last<br><b>FILER</b>                                                                                                                                                                                                                                  |                                       | 4. DATE OF DEATH<br>Month<br><b>FEB.</b><br>Day<br><b>22,</b><br>Year<br><b>19 59</b>                                                                       |                                                                        |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                           | 6. COLOR OR RACE<br><b>white</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 28, 1875</b>                              |
| 9. AGE (In years lost birthday)<br><b>83</b> yrs.                                                                                                                                                                                                                                                                                               |                                       | 10. IF UNDER 1 YEAR<br>Months<br><b>3</b><br>Days<br><b>1</b><br>Hours<br><b>15</b><br>Min.                                                                 |                                                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired miner</b>                                                                                                                                                                                                                             |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal mines</b>                                                                                                      |                                                                        |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                        |
| 13. FATHER'S NAME<br><b>Benjamin Filer</b>                                                                                                                                                                                                                                                                                                      |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Millard</b>                                                                                                           |                                                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                 |                                       | 16. SOCIAL SECURITY NO.<br><b>220-10-2748</b>                                                                                                               |                                                                        |
| 17. INFORMANT<br><b>Mrs. Millie Cosgrove,</b>                                                                                                                                                                                                                                                                                                   |                                       | Address<br><b>Frostburg, Md.</b>                                                                                                                            |                                                                        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.<br>(b)<br><b>myocardial insufficiency</b><br>(c)<br><b>arterio sclerosis</b> |                                       | INTERVAL BETWEEN ONSET OF DEATH<br><b>3 years</b><br><b>several</b><br><b>years</b>                                                                         |                                                                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                               |                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                      |                                                                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                        |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>                                                                                                                                                                                                                                                                     |                                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                                                        |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                          |                                       | 20f. (City or town) (County) (State)                                                                                                                        |                                                                        |
| 21. I certify that I attended the deceased from <b>1956</b> , 19____, to <b>Feb 22, 1959</b> , that I last saw the deceased alive on <b>Feb 20, 1959</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above.                                                                                            |                                       |                                                                                                                                                             |                                                                        |
| ACTUAL SIGNATURE<br><b>W O McLane</b>                                                                                                                                                                                                                                                                                                           |                                       | DATE SIGNED<br><b>Feb 23 1959</b>                                                                                                                           |                                                                        |
| PHYSICIAN'S NAME (Type)<br><b>W. O. McLane, M. D.</b>                                                                                                                                                                                                                                                                                           |                                       | <b>Frostburg, Md.</b>                                                                                                                                       |                                                                        |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                      | 22b. DATE THEREOF<br><b>2-25-1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>                                                                                            | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst, Frostburg, Md.</b>                                                                                                                                                                                                                                                                          |                                       | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 25 '59</b>                                                                                                           |                                                                        |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>                                                                                                                                                                                                                                                                                            |                                       |                                                                                                                                                             |                                                                        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CONFIDENTIAL

U. S. Forest, Frostburg, Md.  
8-22-1952  
Type: Memorial Park  
Frostburg, Md.

W. O. Nelson, Jr. I.  
Frostburg, Md.

U. S. Forest

220-10-0748 Mrs. Willie Googrove, Frostburg, Md.

Benjamin Elmer

Wanda Willard

Retired Miner

Coal Mines

Tennsylvania

U.S.A.

White

X

2. 28. 1875

33

BRITAIN

C.

PRIN

222.

33

33

Frostburg

1 week

Midnight

Agency

Midnight

Agency

1952

CERTIFICATE OF DEATH

1952



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1393

CERTIFICATE OF DEATH

01362

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                |                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                         | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |                                                   |                                                                                                |                                                                                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>                                                                                                                                                                                                                       |                                  |                                                                                                                                                             |                                         | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>                                           |                                                   |                                                                                                |                                                                                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                         | d. STREET ADDRESS <b>55 Broadway</b>                                                                                                        |                                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANNA</b> Middle <b>MARGARET</b> Last <b>FINZEL</b>                                                                                                                                                                                                                      |                                  |                                                                                                                                                             |                                         | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>11</b> , Year <b>19 59</b>                                                                 |                                                   |                                                                                                |                                                                                                |
| 5. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                 | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 2, 1888</b> |                                                                                                                                             | 9. AGE (In years lost birthday)<br><b>70</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                      | IF UNDER 24 HRS.<br>Hours Min.                                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic cook</b>                                                                                                                                                                                                     |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private home</b>                                                                                                    |                                         | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                |                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                |
| 13. FATHER'S NAME<br><b>Charles Finzel</b>                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                         | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Festerman</b>                                                                                         |                                                   |                                                                                                |                                                                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                               |                                  | 16. SOCIAL SECURITY NO.<br><b>181-26-1789</b>                                                                                                               |                                         | INFORMANT Address<br><b>Mrs. Louise Caton, Frostburg, Md.</b>                                                                               |                                                   |                                                                                                |                                                                                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>578x</b> <b>DUE TO</b> <b>Gangrene of Descending Colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>DUE TO</b> (c) |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>                                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>                                                                                                                                                                           |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                         |                                                                                                                                             |                                                   |                                                                                                |                                                                                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                      |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                      |                                                   | 20f. (City or town) (County) (State)                                                           |                                                                                                |
| 21. I certify that I attended the deceased from <b>2/4</b> , 19 <b>59</b> , to <b>2/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/11</b> , 19 <b>59</b> , and that death occurred at <b>6:05 A.M.</b> , from the causes and on the date stated above.                                              |                                  |                                                                                                                                                             |                                         |                                                                                                                                             |                                                   |                                                                                                |                                                                                                |
| ACTUAL SIGNATURE<br><b>Martin Rothstein, M.D.</b>                                                                                                                                                                                                                                                                       |                                  | ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b> DATE SIGNED                                                                        |                                         |                                                                                                                                             |                                                   |                                                                                                |                                                                                                |
| PHYSICIAN'S NAME (Type)<br><b>Martin Rothstein, M. D.</b>                                                                                                                                                                                                                                                               |                                  | <b>Frostburg, Md.</b>                                                                                                                                       |                                         |                                                                                                                                             |                                                   |                                                                                                |                                                                                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                              |                                  | 22b. DATE THEREOF<br><b>Feb. 6 '59</b>                                                                                                                      |                                         | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Finzel Cemetery</b>                                                                                |                                                   | 22d. LOCATION (City, town, or county) (State)<br><b>Finzel, Md.</b>                            |                                                                                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst,</b>                                                                                                                                                                                                                                                                 |                                  | ADDRESS<br><b>Frostburg, Md.</b>                                                                                                                            |                                         | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 16 '59</b>                                                                                           |                                                   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>                                           |                                                                                                |



CERTIFICATE OF DEATH

1933

Allegany

Proctor

2 days

Proctor

River's Hospital

22 Broadway

Anna

MARGARET

RIVER

February 18, 1933

Female white

Oct. 2, 1888

Domestic cook

Private home

Maryland

U.S.A.

Charles River

William Proctor

181-26-1782 Mrs. Louise C. Proctor, Md.

18 Broadway

Proctor, Md.

Mrs. Louise C. Proctor, Md.

Md.

Feb. 18, 1933

Feb. 18, 1933 (Proctor)

J. J. Proctor, Md.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01363

1394

|                                                                                                                                                                                                                                                                                                          |                                                                                                                                                             |                                                                                                                                                             |                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Allegany</u><br>MARYLAND                                                                                                                                                                                                                                               |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md</u><br>b. COUNTY <u>Allegany</u>                    |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westernport</u>                                                                                                                                                                                                   | c. LENGTH OF STAY IN 1b<br><u>35 Yrs</u>                                                                                                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westernport</u>                                                      |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>304 Md. Ave.</u>                                                                                                                                                                                                      |                                                                                                                                                             | d. STREET ADDRESS<br><u>304 Md. Ave.</u>                                                                                                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Harry</u> Middle <u>Lloyd</u> Last <u>Foreman</u>                                                                                                                                                                                                        |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>6</u> Year <u>1959</u>                                                                                         |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><u>White</u>                                                                                                                            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 9, 1900</u>                                                           |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.                                                                                                                                                                                                                                                        |                                                                                                                                                             | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                                                                           | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Power Plant Supt.</u>                                                                                                                                                                                  |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Paper Mill</u>                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Penn.</u>                                         |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                                                                                                                                                                                                                              |                                                                                                                                                             | 13. FATHER'S NAME<br><u>Harry M. Foreman</u>                                                                                                                |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><u>Anna Ott.</u>                                                                                                                                                                                                                                                             |                                                                                                                                                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>                                                                             |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) <u>217-05-4636</u>                                                                                                                                                                                                                     |                                                                                                                                                             | 17. INFORMANT<br>Address<br><u>Mrs. Hazel Foreman-Westernport, Md.</u>                                                                                      |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocarditis</u><br><u>422.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) <u>  </u> |                                                                                                                                                             |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yr</u>                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                        |                                                                                                                                                             |                                                                                                                                                             | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                       |                                                                                                                                                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>19</u>                                                                                                                                                                                                                          | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town) (County) (State)                                                              |
| 21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>57</u> , to <u>2/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/6/59</u> , 19 <u>  </u> , and that death occurred at <u>6 A</u> . M, from the causes and on the date stated above.                                |                                                                                                                                                             |                                                                                                                                                             |                                                                                                   |
| ACTUAL SIGNATURE<br><u>P. E. Berry</u>                                                                                                                                                                                                                                                                   |                                                                                                                                                             | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>Biedmont, W. Va.</u>                                                                                |                                                                                                   |
| PHYSICIAN'S NAME (Type)<br><u>P. E. Berry</u>                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                                                                                             |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                               | 22b. DATE THEREOF<br><u>2/8/59</u>                                                                                                                          | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Lawn Mem. Garden</u>                                                                                          | 22d. LOCATION (City, town, or county) (State)<br><u>LaVale Md.</u>                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>E. L. Boral</u>                                                                                                                                                                                                                                                   |                                                                                                                                                             | ADDRESS<br><u>Westernport, Md.</u>                                                                                                                          | 24a. REC'D BY REGISTRAR<br>DATE <u>FEB 9 '59</u>                                                  |
|                                                                                                                                                                                                                                                                                                          |                                                                                                                                                             | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Krouse</u>                                                                                                       |                                                                                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS DEPARTMENT OF HIGHWAYS—BALTIMORE 18



1357

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                     |                                                                                                                                                          |                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |                                                                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                   |                                     | c. LENGTH OF STAY IN lb<br><b>16 DAYS</b>                                                                                                                |                                                                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                            |                                     | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                           |                                                                             |
| 3. NAME OF DECEASED (Type or print)<br><b>ELLA</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                     | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>9</b> Year <b>19 59</b>                                                                                     |                                                                             |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 8, 1880</b>                                     |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                       |                                     | 10. IF UNDER 1 YEAR Months Days Hours Min.                                                                                                               |                                                                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                         |                                     | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |                                                                             |
| 11. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                               |                                                                             |
| 13. FATHER'S NAME<br><b>Thomas Hemings</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Alice Haney</b>                                                                                                           |                                                                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                     |                                     | 16. SOCIAL SECURITY NO.                                                                                                                                  |                                                                             |
| 17. INFORMANT<br><b>PATIENTS CHART</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                     | Address                                                                                                                                                  |                                                                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardio-vascular &amp; Renal Disease</b><br>(c) <b>Hypertensive and Atherosclerotic</b><br><b>AND GANGRENE AMPUTATION, left, mid thigh</b><br>Due to Diabetes with Gangrene 12 days |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>1-2 years</b><br><b>2 months</b>                                                                 |                                                                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                       |                                     | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                             |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19                                                                                                                                                                                                                                                                                                                                                                                             |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                                                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                  |                                     | 20f. (City or town) (County) (State)                                                                                                                     |                                                                             |
| 21. I certify that I attended the deceased from <b>23 Jan 1959</b> , to <b>9 Feb 1959</b> , that I last saw the deceased alive on <b>8 Feb 1959</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.                                                                                                                                                                                                         |                                     |                                                                                                                                                          |                                                                             |
| ACTUAL SIGNATURE<br><b>A. C. Weisman M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                                     | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>59 Greene St. Cumberland, Md. 2/9/59</b>                                                         |                                                                             |
| PHYSICIAN'S NAME (Type)<br><b>S. G. Weisman, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                     | Cumberland, Md. Greene St., Cumberland, Md.                                                                                                              |                                                                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              | 22b. DATE THEREOF<br><b>2-11-59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Ann's Cemetery</b>                                                                                          | 22d. LOCATION (City, town, or county) (State)<br><b>Garrett County, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Durst, Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                                              |                                     | 24a. REC'D BY REGISTRAR<br><b>FEB 13 59</b>                                                                                                              |                                                                             |
| ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>C. J. S. K.</b>                                                                                                         |                                                                             |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1358

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Allegany</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u><br>c. LENGTH OF STAY IN lb<br><u>50 minutes</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Sacred Heart Hospital</u>                                                                                                                                                                                                                                                              |  |                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Allegany</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u><br>d. STREET ADDRESS<br><u>219 Pennsylvania Ave.</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                         |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Dorothy A. Gilbert</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                           |  | 4. DATE OF DEATH<br>Month Day Year<br><u>February 1 1959</u>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                         |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. COLOR OR RACE<br><u>White</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                |  | 8. DATE OF BIRTH<br><u>1915 Aug. 29, 1915</u>                           |  |
| 9. AGE (In years last birthday)<br><u>43</u> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                         |  |
| 13. FATHER'S NAME<br><u>Adam Oster (Deceased)</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>Alberta Ruby (Deceased)</u>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                         |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><u>no</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                           |  | 16. SOCIAL SECURITY NO.<br><u>212-24-1325</u>                                                                                                                                                                                                                                                                                                                                                                              |  | 17. INFORMANT<br><u>Chart</u>                                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u><br><u>241X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchus Asthma</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                         |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                                                                                                                                                                               |  |                                                                         |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)<br><u>19</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                           |  | 20g. (County)<br><u>19</u>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20h. (State)<br><u>19</u>                                               |  |
| 21. I certify that I attended the deceased from <u>Jan. 28, 1959</u> to <u>Feb. 1, 1959</u> , that I last saw the deceased alive on <u>Feb. 1, 1959</u> , and that death occurred at <u>1:38 P.M.</u> , from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                   |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                         |  |
| ACTUAL SIGNATURE<br><u>Clayton Durrett</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  | ADDRESS (Street, city or town, state)<br><u>236 Va. Ave.</u><br>DATE SIGNED<br><u>2/3/59</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                         |  |
| PHYSICIAN'S NAME (Type)<br><u>C.E. Durrett, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                           |  | <u>236 Virginia Ave. Cumberland, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                         |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22b. DATE THEREOF<br><u>Feb. 4, 1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Memorial Park</u>                                                                                                                                                                                                                                                                                                                                                          |  | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>James F. Scarpelli</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                           |  | ADDRESS<br><u>Cumberland, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                          |  | 24a. REC'D BY REGISTRAR<br>DATE <u>FEB 5 '59</u>                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



CERTIFICATE OF DEATH

1900

|                              |  |                               |  |                                 |  |                              |  |
|------------------------------|--|-------------------------------|--|---------------------------------|--|------------------------------|--|
| <p>1. Name of deceased</p>   |  | <p>2. Sex</p>                 |  | <p>3. Age</p>                   |  | <p>4. Date of birth</p>      |  |
| <p>5. Place of birth</p>     |  | <p>6. Usual residence</p>     |  | <p>7. Date of death</p>         |  | <p>8. Time of death</p>      |  |
| <p>9. Cause of death</p>     |  | <p>10. Nature of disease</p>  |  | <p>11. Duration of disease</p>  |  | <p>12. Place of death</p>    |  |
| <p>13. Name of physician</p> |  | <p>14. Name of undertaker</p> |  | <p>15. Name of funeral home</p> |  | <p>16. Name of cemetery</p>  |  |
| <p>17. Name of registrar</p> |  | <p>18. Name of witness</p>    |  | <p>19. Name of informant</p>    |  | <p>20. Name of informant</p> |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01367

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                                                    |                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b> |                                                                                                                    |                                                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                     |                                  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>                                                                                                                     |                                                                                                                                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT ASHBY</b> <b>85X-3</b> |                                                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL-MEMORIAL AND WARWICK AVES.</b>                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             | d. STREET ADDRESS                                                                                                                               |                                                                                                                    |                                                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EUGENE</b> Middle <b>HARRY</b> Last <b>Gulick</b>                                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>5</b> Year <b>19 59</b>                                                                            |                                                                                                                    |                                                                      |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCTOBER 17, 1911</b> <b>47</b> yrs.                                                                                      |                                                                                                                    | 9. AGE (In years last birthday)<br><b>47</b> yrs.                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self Employed</b>                                                                                                                                                                                                                                                                                                                                                       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Sales Bus.</b>                                                                                                 |                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA Romney</b>                                           |                                                                      |
| 13. FATHER'S NAME<br><b>HOWARD E. GULICK</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>GRACE P BLACKBURG</b>                                                                                            |                                                                                                                    |                                                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                  | 16. SOCIAL SECURITY NO.<br><b>577-48-8548</b>                                                                                                               |                                                                                                                                                 | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>                                           |                                                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>900.0 Maceration of Brain</b><br>DUE TO (b) <b>Skull Fracture</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)                                                                                                                                                               |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>29 Hrs.</b><br><b>29 Hrs.</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                                                    |                                                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                               |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell down steps at home</b>                              |                                                                                                                                                 |                                                                                                                    |                                                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>2:00 a.m. Feb. 4 1959</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                        |                                                                                                                                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                              |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 20f. (City or town)<br><b>FORT ASHBY MINERAL</b>                                                                                                            |                                                                                                                                                 | (County) <b>W.VA.</b> (State)                                                                                      |                                                                      |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                                                    |                                                                      |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | M.D.                                                                                                                                                        |                                                                                                                                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                    |                                                                      |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |                                                                                                                                                 | DATE SIGNED <b>Feb. 5, 1959</b>                                                                                    |                                                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 22b. DATE THEREOF<br><b>2/8/59</b>                                                                                                                          |                                                                                                                                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcres Burial Park</b>                                                  |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                                                                 | 22d. LOCATION (City, town, or county)<br><b>Cumberland, Maryland</b>                                               |                                                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br><b>FEB 11 1959</b>                                                                                                   |                                                                                                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur P. Hagan</b>                 |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1360 CERTIFICATE OF DEATH

01368

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Allegany</u> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |  |                                                                                                                                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u>                                                        |  |                                                                                                                                |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>807 Mt Royal Ave</u>                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  | d. STREET ADDRESS<br><u>1807 Mt Royal Ave.</u>                                                                                                                  |  |                                                                                                                                |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Milton</u> Middle <u>Hawk</u> Last <u>Hawk</u>                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | <b>4. DATE OF DEATH</b><br>Month <u>Feb.</u> Day <u>11</u> Year <u>1959</u>                                                                                     |  |                                                                                                                                |  |
| <b>5. SEX</b><br><u>Male</u>                                                                                                                                                                                                                                                                                                                                          |  | <b>6. COLOR OR RACE</b><br><u>White</u>                                                                                             |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Aug 9 1877</u>                                                                                   |  |
| <b>9. AGE</b> (In years last birthday) <u>81</u> yrs.                                                                                                                                                                                                                                                                                                                 |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>                                                                           |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>                                                                                                       |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Retired Contractor</u> |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Building</u>                                                                                                                                                                                                                                                                                                           |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Marysville W. Va</u>                                                         |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S. A</u>                                                                                                           |  | <b>13. FATHER'S NAME</b><br><u>George S. Hawk</u>                                                                              |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary Ellen Knight</u>                                                                                                                                                                                                                                                                                                           |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u> |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>                                                                                                                   |  | <b>17. INFORMANT</b><br><u>Mrs. Thelma Hbl. Cumb. Md</u>                                                                       |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>                                           |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>                                                                                                                                                                                                                           |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                              |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  |                                                                                                                                     |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)                                                             |  |                                                                                                                                |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>  </u> a. m. <u>  </u> p. m. Month <u>  </u> Day <u>  </u> Year <u>19</u>                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |  |                                                                                                                                |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  | <b>20f. (City or town)</b> (County) (State)                                                                                                                     |  |                                                                                                                                |  |
| <b>21. I certify that I attended the deceased from</b> <u>1/9</u> <u>1959</u> , to <u>7/11</u> <u>1959</u> , that I last saw the deceased alive on <u>2/10</u> <u>1959</u> , and that death occurred at <u>8:05 A.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u> DATE SIGNED <u>7/11/59</u> |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |
| <b>ACTUAL SIGNATURE</b><br><u>LEO H. LEY JR.</u> M.D.                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | <b>PHYSICIAN'S NAME (Type)</b><br><u>LEO H. LEY JR.</u> <u>Cumberland, Md.</u>                                                                                  |  |                                                                                                                                |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>                                                                                                                                                                                                                                                                                                     |  | <b>22b. DATE THEREOF</b><br><u>2/13/59</u>                                                                                          |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Hickwood Cem.</u>                                                                                               |  | <b>22d. LOCATION (City, town, or county)</b> (State)<br><u>Cumberland Md</u>                                                   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Louis Stein Inc. Cumb. Md</u>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  | <b>24a. REC'D BY REGISTRAR</b><br>DATE <u>FEB 16 '59</u>                                                                                                        |  |                                                                                                                                |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Hines</u>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  |                                                                                                                                                                 |  |                                                                                                                                |  |



CERTIFICATE OF DEATH

|                                                                  |  |                                                                                 |  |                                                                    |  |
|------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| NAME OF DECEASED<br>[Faint text, possibly "John Doe"]            |  | SEX<br>[Faint text, possibly "Male"]                                            |  | AGE<br>[Faint text, possibly "45"]                                 |  |
| PLACE OF BIRTH<br>[Faint text, possibly "Baltimore, Md."]        |  | DATE OF BIRTH<br>[Faint text, possibly "Jan 15, 1900"]                          |  | PLACE OF DEATH<br>[Faint text, possibly "Baltimore, Md."]          |  |
| OCCUPATION<br>[Faint text, possibly "Teacher"]                   |  | CAUSE OF DEATH<br>[Faint text, possibly "Heart Disease"]                        |  | MANNER OF DEATH<br>[Faint text, possibly "Natural"]                |  |
| DATE OF DEATH<br>[Faint text, possibly "Dec 10, 1945"]           |  | TIME OF DEATH<br>[Faint text, possibly "10:30 AM"]                              |  | PLACE OF INTERMENT<br>[Faint text, possibly "St. Mary's Cemetery"] |  |
| NAME OF PHYSICIAN<br>[Faint text, possibly "Dr. J. H. Smith"]    |  | NAME OF CLERGYPERSON<br>[Faint text, possibly "Rev. W. B. Jones"]               |  | NAME OF FUNERAL HOME<br>[Faint text, possibly "The Funeral Home"]  |  |
| NAME OF NEXT OF KIN<br>[Faint text, possibly "Mrs. J. H. Smith"] |  | ADDRESS OF NEXT OF KIN<br>[Faint text, possibly "123 Main St., Baltimore, Md."] |  | NAME OF REGISTRAR<br>[Faint text, possibly "John Doe"]             |  |
| SIGNATURE OF PHYSICIAN<br>[Faint signature]                      |  | SIGNATURE OF CLERGYPERSON<br>[Faint signature]                                  |  | SIGNATURE OF FUNERAL HOME<br>[Faint signature]                     |  |
| SIGNATURE OF NEXT OF KIN<br>[Faint signature]                    |  | SIGNATURE OF REGISTRAR<br>[Faint signature]                                     |  | OFFICIAL USE<br>[Faint text]                                       |  |

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

J. H. SMITH, Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1361

## CERTIFICATE OF DEATH

01369

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |                                                                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                               |  | c. LENGTH OF STAY IN 1b<br><b>12 HRS. 5 MIN. 02 CUMBERLAND</b>                                                                                           |  |                                                                               |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                               |  | d. STREET ADDRESS<br><b>825 OLDTOWN, RD.</b>                                                                                                             |  |                                                                               |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ILEY</b> Middle <b>Mann</b> Last <b>HIETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |  | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>18</b> Year <b>19 59</b>                                                                                    |  |                                                                               |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. COLOR OR RACE<br><b>WHITE</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 11, 1895 63</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | IF UNDER 1 YEAR<br>Months Days Hours Min.     |  | IF UNDER 24 HRS.<br>Months Days Hours Min.                                                                                                               |  |                                                                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired shipping clerk Kelly-Tire Co</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fulton Co. Penna.</b>                                                                                            |  |                                                                               |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                            |  |                                                                               |  |
| 13. FATHER'S NAME<br><b>Luther Hielt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Winters</b>                                                                                                        |  |                                                                               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO.<br><b>218-16-2815</b> |  | 17. INFORMANT<br><b>Mrs. Ethel M. Truax</b>                                                                                                              |  | Address<br><b>Hancock, Maryland</b>                                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b><br><b>3-4 yrs</b> |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |  |                                                                               |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) (County) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |
| 21. I certify that I attended the deceased from <b>Feb 5, 1957</b> to <b>Feb 17, 1957</b> , that I last saw the deceased alive on <b>Feb 12, 1957</b> , and that death occurred at <b>9:51 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>441 N. CENTRE ST., CUMBERLAND, MD.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>William P. James</b> M.D. <b>441 N. CENTRE ST., CUMBERLAND, MD.</b><br>PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M.D.</b> <b>441 N. CENTRE ST., CUMBERLAND, MD.</b>                           |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22b. DATE THEREOF<br><b>2/22/59</b>           |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Tonoloway Baptist Cem.</b>                                                                                      |  | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Hancock, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                               |  | ADDRESS<br><b>Cumberland, Maryland</b>                                                                                                                   |  | 24a. REC'D BY REGISTRAR<br><b>FEB 24 59</b>                                   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hays</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                               |  |                                                                                                                                                          |  |                                                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1900

REG. NO. 10

|                                      |  |                                      |  |
|--------------------------------------|--|--------------------------------------|--|
| <p>1. NAME OF DECEASED</p>           |  | <p>2. SEX</p>                        |  |
| <p>3. AGE</p>                        |  | <p>4. DATE OF BIRTH</p>              |  |
| <p>5. PLACE OF BIRTH</p>             |  | <p>6. DATE OF DEATH</p>              |  |
| <p>7. TIME OF DEATH</p>              |  | <p>8. PLACE OF DEATH</p>             |  |
| <p>9. CAUSE OF DEATH</p>             |  | <p>10. MANNER OF DEATH</p>           |  |
| <p>11. SIGNATURE OF PHYSICIAN</p>    |  | <p>12. SIGNATURE OF REGISTRAR</p>    |  |
| <p>13. SIGNATURE OF WITNESSES</p>    |  | <p>14. SIGNATURE OF DECEASED</p>     |  |
| <p>15. SIGNATURE OF FUNERAL HOME</p> |  | <p>16. SIGNATURE OF BURIAL PLACE</p> |  |
| <p>17. SIGNATURE OF CEMETERY</p>     |  | <p>18. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>19. SIGNATURE OF INTERVIEWER</p>  |  | <p>20. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>21. SIGNATURE OF INTERVIEWER</p>  |  | <p>22. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>23. SIGNATURE OF INTERVIEWER</p>  |  | <p>24. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>25. SIGNATURE OF INTERVIEWER</p>  |  | <p>26. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>27. SIGNATURE OF INTERVIEWER</p>  |  | <p>28. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>29. SIGNATURE OF INTERVIEWER</p>  |  | <p>30. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>31. SIGNATURE OF INTERVIEWER</p>  |  | <p>32. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>33. SIGNATURE OF INTERVIEWER</p>  |  | <p>34. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>35. SIGNATURE OF INTERVIEWER</p>  |  | <p>36. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>37. SIGNATURE OF INTERVIEWER</p>  |  | <p>38. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>39. SIGNATURE OF INTERVIEWER</p>  |  | <p>40. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>41. SIGNATURE OF INTERVIEWER</p>  |  | <p>42. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>43. SIGNATURE OF INTERVIEWER</p>  |  | <p>44. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>45. SIGNATURE OF INTERVIEWER</p>  |  | <p>46. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>47. SIGNATURE OF INTERVIEWER</p>  |  | <p>48. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>49. SIGNATURE OF INTERVIEWER</p>  |  | <p>50. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>51. SIGNATURE OF INTERVIEWER</p>  |  | <p>52. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>53. SIGNATURE OF INTERVIEWER</p>  |  | <p>54. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>55. SIGNATURE OF INTERVIEWER</p>  |  | <p>56. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>57. SIGNATURE OF INTERVIEWER</p>  |  | <p>58. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>59. SIGNATURE OF INTERVIEWER</p>  |  | <p>60. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>61. SIGNATURE OF INTERVIEWER</p>  |  | <p>62. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>63. SIGNATURE OF INTERVIEWER</p>  |  | <p>64. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>65. SIGNATURE OF INTERVIEWER</p>  |  | <p>66. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>67. SIGNATURE OF INTERVIEWER</p>  |  | <p>68. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>69. SIGNATURE OF INTERVIEWER</p>  |  | <p>70. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>71. SIGNATURE OF INTERVIEWER</p>  |  | <p>72. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>73. SIGNATURE OF INTERVIEWER</p>  |  | <p>74. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>75. SIGNATURE OF INTERVIEWER</p>  |  | <p>76. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>77. SIGNATURE OF INTERVIEWER</p>  |  | <p>78. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>79. SIGNATURE OF INTERVIEWER</p>  |  | <p>80. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>81. SIGNATURE OF INTERVIEWER</p>  |  | <p>82. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>83. SIGNATURE OF INTERVIEWER</p>  |  | <p>84. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>85. SIGNATURE OF INTERVIEWER</p>  |  | <p>86. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>87. SIGNATURE OF INTERVIEWER</p>  |  | <p>88. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>89. SIGNATURE OF INTERVIEWER</p>  |  | <p>90. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>91. SIGNATURE OF INTERVIEWER</p>  |  | <p>92. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>93. SIGNATURE OF INTERVIEWER</p>  |  | <p>94. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>95. SIGNATURE OF INTERVIEWER</p>  |  | <p>96. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>97. SIGNATURE OF INTERVIEWER</p>  |  | <p>98. SIGNATURE OF INTERVIEWER</p>  |  |
| <p>99. SIGNATURE OF INTERVIEWER</p>  |  | <p>100. SIGNATURE OF INTERVIEWER</p> |  |





1395

## CERTIFICATE OF DEATH

01370

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                          |                                                                                                                                                          |                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                    |                                          | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                                       | c. LENGTH OF STAY IN 1b<br><b>3 days</b> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Midlothian</b>                                                    |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miners Hospital</b>                                                                                                                                                                                                                                                                                                                                                     |                                          | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AGNES</b> Middle <b>(WALKER)</b> Last <b>HITCHINS</b>                                                                                                                                                                                                                                                                                                                                                      |                                          | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>1,</b> Year <b>19 59</b>                                                                                    |                                      |
| 5. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>white</b>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-29-1908</b> |
| 9. AGE (In years last birthday) yrs. <b>50</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                          | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housework</b>                                                                                                                                                                                                                                                                                                                                            |                                          | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                                                                                                     |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                            |                                      |
| 13. FATHER'S NAME<br><b>James Walker</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                          | 14. MOTHER'S MAIDEN NAME<br><b>Janet Brimlow</b>                                                                                                         |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                  |                                          | 16. SOCIAL SECURITY NO.<br><b>none</b>                                                                                                                   |                                      |
| 17. INFORMANT<br><b>Wm. Hitchins, Midlothian, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                          | Address                                                                                                                                                  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>260x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>60 hrs</b><br><b>18 yrs</b><br><b>? 9 yrs</b> |                                          |                                                                                                                                                          |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetic Acidosis; Hemiplegia L.</b>                                                                                                                                                                                                                                                                               |                                          |                                                                                                                                                          |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |                                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                          | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                     |                                          | 20f. (City or town) (County) (State)                                                                                                                     |                                      |
| 21. I certify that I attended the deceased from <b>1/29, 1959</b> , to <b>2/1, 1959</b> , that I last saw the deceased alive on <b>2/1, 1959</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>26 W. Mechanic St.,</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Frank T. Harrat</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>F. T. Harrat, M. D.</b> <b>Frostburg, Md.</b>   |                                          |                                                                                                                                                          |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                          | 22b. DATE THEREOF<br><b>Feb. 3 '59</b>                                                                                                                   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                          | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Md.</b>                                                                                   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst,</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                          | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 4 '59</b>                                                                                                         |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Harris</i>                                                                                                                                                                                                                                                                                                                                                                                                      |                                          |                                                                                                                                                          |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1997

2567495-2



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1362

## CERTIFICATE OF DEATH

01371

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |                                                                                                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                      |  | c. LENGTH OF STAY IN b<br><b>12 hrs</b>                                                                   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b>                                                 |  |                                                                                                |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | d. STREET ADDRESS<br><b>811 MEMORIAL AVE.</b>                                                                                                            |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRED</b> Middle <b>H</b> Last <b>HOLLEN</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>2</b> Year <b>1959</b>                                                                                      |  |                                                                                                |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 24, 1899</b>                                                       |  |
| 9. AGE (In years last birthday)<br><b>59</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                          |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                 |  | IF UNDER 24 HRS.<br>Months Days Hours Min.                                                                                                               |  |                                                                                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car Foreman</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O Railroad</b>                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maysville W.V.A.</b>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                                                |  |
| 13. FATHER'S NAME<br><b>Wellington R P. Hollen</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Harman</b>                                                                                                       |  |                                                                                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><b>US Navy 705-09-9670</b>                                                     |  | 17. INFORMANT<br><b>WIFE CATHERINE Hollen</b> Address <b>811 MEMORIAL AVE.</b>                                                                           |  |                                                                                                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Acute Myocardial Failure Sudden</b><br>DUE TO (b) <b>Acute massive myocardial infarction - Coronary Thrombosis</b><br>DUE TO (c) <b>Coronary Sclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary Sclerosis</b>     |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                                                |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                                                |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |  |                                                                                                |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                   |  | 20f. (City or town) (County) (State)                                                           |  |
| 21. I certify that I attended the deceased from <b>2/2</b> 19 <b>59</b> , to <b>2/2</b> 19 <b>59</b> , that I last saw the deceased alive on <b>2/2</b> 19 <b>59</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>54 GREENE ST</b> DATE SIGNED <b>2/3/59</b><br>ACTUAL SIGNATURE <b>W. J. Greenerman</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN MD CUMBERLAND, MD</b> |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                                                |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22b. DATE THEREOF<br><b>Feb. 5, 1959</b>                                                                  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cath. Cem.</b>                                                                                       |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 24a. REC'D BY REGISTRAR<br><b>FEB 11 '59</b>                                                                                                             |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hafer</i>                                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1363

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01372

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                          | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |                                                                                            |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>                                                                                                                                                                                                                                                                                                                                                                |                                  | c. LENGTH OF STAY IN 1b<br><u>Life</u>                                                                                                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland Md.</u>                                |                                                                                            |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>317 Pulaski Street</u>                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                          | d. STREET ADDRESS<br><u>317 Pulaski St.</u>                                                                                                 |                                                                                            | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>F.</u> Last <u>Holzen</u>                                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                          | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>7</u> Year <u>1959</u>                                                                         |                                                                                            |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/7/82</u>                                                                                                           |                                                                                            | 9. AGE (In years last birthday)<br><u>76</u> yrs.                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired City Employee Steel Dept.</u>                                                                                                                                                                                                                                                                                                                              |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Cumberland Md.</u>                                                                                               |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>                                 |                                                                                                   |
| 13. FATHER'S NAME<br><u>John Holzen</u>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                          | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Palace</u>                                                                                         |                                                                                            |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                      |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                                   |                                                                                                                                             | 17. INFORMANT<br><u>Bill Koelher</u> Address <u>Cumb. Md</u>                               |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |                                                                                                                                                          |                                                                                                                                             |                                                                                            | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>                                                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                |                                                                                            |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>                                                                                                                                                                                                                                                                                                                                                                                             |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |                                                                                                                                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Cumb. Md.</u> |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>                    |                                  |                                                                                                                                                          |                                                                                                                                             |                                                                                            |                                                                                                   |
| ACTUAL SIGNATURE <u>Benedict Skitarolic, M.D.</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                             |                                                                                            |                                                                                                   |
| EXAMINER'S NAME (Type) <u>Benedict Skitarolic M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                         |                                                                                            |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 9, 1959</u>                                                             |                                                                                            |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 22b. DATE THEREOF<br><u>2/9/59</u>                                                                                                                       |                                                                                                                                             | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Peter + Paul Cm.</u>                          |                                                                                                   |
| 22d. LOCATION (City, town, or county)<br><u>Cumb. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                            |                                  | 22e. (State)<br><u>Md.</u>                                                                                                                               |                                                                                                                                             | 22f. (City or town)<br><u>Cumb.</u>                                                        |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Stein Inc.</u>                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                          | 24a. REC'D BY REGISTRAR<br><u>FEB 11 '59</u>                                                                                                |                                                                                            |                                                                                                   |
| ADDRESS<br><u>Cumb. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                          | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                                                                                        |                                                                                            |                                                                                                   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







1364

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                   |                                                                                                                                             |                                                                                   |                                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |                                                                                   |                                                                                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>                                                                                                                                                                                                                                                                         |                                  | c. LENGTH OF STAY IN 1b<br><u>5 days</u>                                                                                                                    |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u>                                    |                                                                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Sacred Heart Hospital</u>                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                   | d. STREET ADDRESS<br><u>30 West 1st Street</u>                                                                                              |                                                                                   |                                                                                                   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rebecca</u> Middle <u>Hook</u> Last <u>Hook</u>                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                   | 4. DATE OF DEATH<br>Month <u>Feb</u> Day <u>2</u> Year <u>19 59</u>                                                                         |                                                                                   |                                                                                                   |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1/5/76</u> | 9. AGE (In years last birthday)<br><u>82</u> yrs.                                                                                           | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                               |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>                                                                                                            |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                |                                                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                     |  |
| 13. FATHER'S NAME<br><u>Henry C. Warnick</u>                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Jane Paul</u>                                                                                           |                                                                                   |                                                                                                   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>16</u>                                                                                                                                                                                                                                                         |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                                      |                                   | 17. INFORMANT<br><u>Pt.'s Chart</u>                                                                                                         |                                                                                   |                                                                                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Uremic Poisoning</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Not Known</u>                            |                                  |                                                                                                                                                             |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u>                                                                                           |                                                                                   |                                                                                                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                           |                                  |                                                                                                                                                             |                                   |                                                                                                                                             |                                                                                   |                                                                                                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |                                  |                                                                                                                                                             |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                |                                                                                   |                                                                                                   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. 19<br>p. m.                                                                                                                                                                                                                                                                                                             |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                      |                                                                                   | 20f. (City or town) (County) (State)                                                              |  |
| 21. I certify that I attended the deceased from <u>1-30</u> , 19 <u>59</u> , to <u>2-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>59</u> , and that death occurred at <u>1:07 A.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>16 Green St Cumberland Md</u> DATE SIGNED <u>2-2-59</u> |                                  |                                                                                                                                                             |                                   |                                                                                                                                             |                                                                                   |                                                                                                   |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>16 Green St Cumberland Md</u>                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                   | DATE SIGNED <u>2-2-59</u>                                                                                                                   |                                                                                   |                                                                                                   |  |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                             |                                   |                                                                                                                                             |                                                                                   |                                                                                                   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                    |                                  | 22b. DATE THEREOF<br><u>2/4/59</u>                                                                                                                          |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Home. Pk</u>                                                                                |                                                                                   | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland Md</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Stein Inc.</u>                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                   | ADDRESS<br><u>Cumb. Md.</u>                                                                                                                 |                                                                                   | 24a. REC'D BY REGISTRAR<br>DATE <u>FEB 5 '59</u>                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hines</u>                                                                                        |                                                                                   |                                                                                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1 *B*  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01374

1365 CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                           |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                           |  |
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| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>     |  | c. LENGTH OF STAY IN 1b<br><b>24 DAYS</b>                                                                 |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>WEST VIRGINIA</b>                          |  | b. COUNTY                                                                                                                                                                                                                                                                 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL<br/>MEMORIAL &amp; WARWICK AVENUES.</b>                                                                                                                                                                                                                                                                                             |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | d. STREET ADDRESS                                                                                         |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓<br><b>PAW PAW</b>                                               |  | 85 x 3                                                                                                                                                                                                                                                                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MICHAEL T. KIDWELL</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4. DATE OF DEATH<br>Month Day Year<br><b>FEBRUARY 27, 1959.</b>                                           |  | 5. SEX<br><b>MALE</b>                                                                                     |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                                                                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                  |  |
| 8. DATE OF BIRTH<br><b>MAY 8, 1956</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 9. AGE (In years last birthday)<br><b>2</b> yrs.                                                          |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                |  | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MD.</b>                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                           |  |
| 13. FATHER'S NAME<br><b>MARSHALL KIDWELL JR.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES HERRELL</b>                                                        |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                                                                                                                            |  | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>                                                                                                                                                                                                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>204.0</b><br><i>Leukemic Leukemia</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 wks</i>                                                          |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                              |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                    |  | 20f. (City or town) (County) (State)                                                                                                               |  | 21. I certify that I attended the deceased from <b>2-23</b> , 19 <b>59</b> , to <b>2-27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-27</b> , 19 <b>59</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above. |  |
| ACTUAL SIGNATURE<br><i>H. W. Eliason</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  | M.D.                                                                                                      |  | ADDRESS (Street, city or town, state)<br><b>126 Union St. Cumberland Md</b>                               |  | DATE SIGNED<br><b>2/27/59</b>                                                                                                                      |  | PHYSICIAN'S NAME (Type)<br><b>DR. H. W. ELIASON</b>                                                                                                                                                                                                                       |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 22b. DATE THEREOF<br><b>3/1/59</b>                                                                        |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>WOODROW W. CEM.</b>                                              |  | 22d. LOCATION (City, town, or county) (State)<br><b>PAW PAW, W. VA.</b>                                                                            |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>C. E. Johnson</i>                                                                                                                                                                                                                  |  |
| 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 2 '59</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hanks</i>                                                      |  | 25. VS A1S (4)<br>15M 10/57                                                                               |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01375

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1366

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                          |                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                                                           | c. LENGTH OF STAY IN 1b                                                                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b>                                                   |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>213 Paca St.,</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | d. STREET ADDRESS<br><b>213 Paca St.,</b>                                                                                                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>GEORGE SEBASTIAN KOTSCHENREUTHER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>20,</b> Year <b>19 59</b>                                                                                   |                                                                                                   |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 18, 1888</b>                                                         |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | IF UNDER 1 YEAR<br>Months <b>70</b> Days <b>70</b>                                                                                                       | IF UNDER 24 HRS.<br>Hours <b>70</b> Min. <b>70</b>                                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Restaurant Prop.</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                                                                                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Md.</b>                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                          |                                                                                                   |
| 13. FATHER'S NAME<br><b>George Kotschenreuther</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Seiss</b>                                                                                                       |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><b>Yes, W.W.#1</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                   | 17. INFORMANT<br><b>Mr. Joseph P. Kotschenreuther LaVale, Md.</b>                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>coronary sclerosis</b><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertensive cardiovascular disease</b> |                                                                                                           |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>                                                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>19</b><br>a. m. <b>19</b><br>p. m.                                                                                                                                                                                                                                                                                                                                                                                                                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                   | 20f. (City or town) (County) (State)                                                              |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                                                  |                                                                                                           |                                                                                                                                                          |                                                                                                   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                          |                                                                                                   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                      |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                              |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 22b. DATE THEREOF<br><b>2/23/59</b>                                                                                                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>S.S. Peter &amp; Paul's</b>                              |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | (State)                                                                                                                                                  |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 24a. REC'D BY REGISTRAR<br><b>February 20, 1959</b>                                                                                                      |                                                                                                   |
| ADDRESS<br><b>Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 24b. REGISTRAR'S SIGNATURE                                                                                                                               |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1966

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                     |  |
|-------------------------------------|--|
| <p>NAME OF DECEASED: _____</p>      |  |
| <p>DATE OF DEATH: _____</p>         |  |
| <p>PLACE OF DEATH: _____</p>        |  |
| <p>AGE: _____</p>                   |  |
| <p>SEX: _____</p>                   |  |
| <p>RACE: _____</p>                  |  |
| <p>EDUCATION: _____</p>             |  |
| <p>OCCUPATION: _____</p>            |  |
| <p>PREVIOUS ILLNESS: _____</p>      |  |
| <p>CAUSE OF DEATH: _____</p>        |  |
| <p>MANNER OF DEATH: _____</p>       |  |
| <p>TIME OF DEATH: _____</p>         |  |
| <p>PLACE OF BURIAL: _____</p>       |  |
| <p>DATE OF BURIAL: _____</p>        |  |
| <p>SIGNATURE OF EXAMINER: _____</p> |  |
| <p>DATE OF SIGNATURE: _____</p>     |  |



1396

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                      |                                                                                                                                        |                                                   |                                                       |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> |                                                   |                                                       |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>22 Frostburg</b>                                |                                                   |                                                       |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miner's Hospital</b>                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                 |                                                   |                                                       |                                                                                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Conrad</b> Last <b>Kroll</b>                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                      | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>28</b> Year <b>19 59</b>                                                                     |                                                   |                                                       |                                                                                                   |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-17-1906</b> |                                                                                                                                        | 9. AGE (In years last birthday)<br><b>52</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.             |                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Storekeeper</b>                                                                                                                                                                                                                                                |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery</b>                                                                                                         |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg, Md.</b>                                                                     |                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>        |                                                                                                   |
| 13. FATHER'S NAME<br><b>Conrad Kroll</b>                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                             |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Ort</b>                                                                                           |                                                   |                                                       |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes World War 2</b>                                                                                                                                                                                                                                                    |                                  | 16. SOCIAL SECURITY NO.<br><b>213-10-9721</b>                                                                                                               |                                      | 17. INFORMANT <b>Mr. Wm. H. Kroll, 99 Washington St.</b> Address                                                                       |                                                   |                                                       |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction (Extensive)</b><br>430.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>following Coronary Occlusion</b><br>DUE TO (c) <b>16 days</b> |                                  |                                                                                                                                                             |                                      |                                                                                                                                        |                                                   |                                                       | INTERVAL BETWEEN ONSET AND DEATH                                                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>obesity</b>                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                      |                                                                                                                                        |                                                   |                                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                      |                                                                                                                                        |                                                   |                                                       |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. 19 p. m.                                                                                                                                                                                                                                                                                                   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                 |                                                   | 20f. (City or town) (County) (State)                  |                                                                                                   |
| 21. I certify that I attended the deceased from <b>2-12</b> , 19 <b>59</b> , to <b>2-28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-28</b> , 19 <b>59</b> , and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above.                                                                                        |                                  |                                                                                                                                                             |                                      |                                                                                                                                        |                                                   |                                                       |                                                                                                   |
| ACTUAL SIGNATURE <b>H. C. Diehl</b>                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                      | ADDRESS (Street, city or town, state) <b>39 W. Main St.</b>                                                                            |                                                   | DATE SIGNED <b>3/1/59</b>                             |                                                                                                   |
| PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M.D.</b>                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                      | <b>Frostburg, Md.</b>                                                                                                                  |                                                   |                                                       |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |                                  | 22b. DATE THEREOF<br><b>3-2-1959</b>                                                                                                                        |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Pk. Frostburg, Md.</b>                                                     |                                                   | 22d. LOCATION (City, town, or county) (State)         |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Carl H. Mattingly</b>                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                      | 24a. REC'D BY REGISTRAR<br><b>Mar 6 '59</b>                                                                                            |                                                   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kneass</b> |                                                                                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1397

CERTIFICATE OF DEATH

Reg. Dist. No.

01377

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>                      |                                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                        |                                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>66 Centennial St.</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                  | d. STREET ADDRESS<br><b>66 Centennial St.</b>                                                                                                               |                                            |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Elizabeth</b> Last <b>Lancaster</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>28</b> Year <b>19 59</b>                                                                                          |                                            |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 1st. 1895</b>  |
| 9. AGE (In years last birthday)<br><b>63 yrs.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                   | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                                                        |                                            |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                             |                                            |
| 13. FATHER'S NAME<br><b>William McKenzie</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Lawson</b>                                                                                                             |                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                             |                                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                            |
| 17. INFORMANT <b>Frostburg, Md.</b> Address<br><b>Mr. James E. Skidmore, 66 Centennial St.</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             |                                            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b><br>DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO (c) <b>Diabetes mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |                                                                                                                                                             |                                            |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hrs -</b><br><b>years -</b><br><b>years -</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                            |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                    |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                            |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |                                            |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 20f. (City or town) (County) (State)                                                                                                                        |                                            |
| 21. I certify that I attended the deceased from <b>March 15, 1959</b> to <b>Feb. 28, 1959</b> , that I last saw the deceased alive on <b>Feb. 15, 1959</b> , and that death occurred at <b>10:22 A.M.</b> , from the causes and on the date stated above.                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                            |
| ACTUAL SIGNATURE<br><b>John B. Davis, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | ADDRESS (Street, city or town, state)<br><b>2 Broadway, Frostburg, Md.</b>                                                                                  |                                            |
| PHYSICIAN'S NAME (Type)<br><b>John B. Davis, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | DATE SIGNED<br><b>3/3/59</b>                                                                                                                                |                                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  | 22b. DATE THEREOF<br><b>3-2-1959</b>                                                                                                                        |                                            |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Pk. Frostburg</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Md.</b>                                                                                                 |                                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Pearl H. Mattingly</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 6 '59</b>                                                                                                            |                                            |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                            |



CERTIFICATE OF DEATH

THIS

DATE OF DEATH

DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

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1367  
CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                  |                                     |                                                                                                                                                          |                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |                                                                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                            |                                     | c. LENGTH OF STAY IN 1b<br><b>02 CUMBERLAND</b>                                                                                                          |                                                                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4 Harrison Street</b>                                                                                                                                                                                                                                                                                         |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                               |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>S.</b> Last <b>Lease</b>                                                                                                                                                                                                                                                                                                  |                                     | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>16th</b> Year <b>19 59</b>                                                                              |                                                                               |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 5, 1865</b>                                  |
| 9. AGE (In years last birthday) yrs. <b>93</b>                                                                                                                                                                                                                                                                                                                                                   |                                     | IF UNDER 1 YEAR Months Days Hours Min.                                                                                                                   |                                                                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                                                         |                                                                               |
| 11. BIRTHPLACE (State or foreign country)<br><b>Rawlings, Maryland</b>                                                                                                                                                                                                                                                                                                                           |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>                                                                                                           |                                                                               |
| 13. FATHER'S NAME<br><b>Wesley Huff</b>                                                                                                                                                                                                                                                                                                                                                          |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                               |                                                                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                                                                                                                                                                                                                                                                                                                  |                                     | 16. SOCIAL SECURITY NO.<br><b>None.</b>                                                                                                                  |                                                                               |
| 17. INFORMANT<br><b>Mr Elmer Lease</b>                                                                                                                                                                                                                                                                                                                                                           |                                     | Address<br><b>Cumb. Md</b>                                                                                                                               |                                                                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease with Cardiomegaly and congestive heart failure</b><br>DUE TO (c) |                                     |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>Many years</b>       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Genitourinary tract infection.</b>                                                                                                                                                                                                                       |                                     |                                                                                                                                                          |                                                                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                               |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                                                               |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                           |                                     | 20f. (City or town) (County) (State)                                                                                                                     |                                                                               |
| 21. I certify that I attended the deceased from <b>November 7th, 1958</b> to <b>February 16th, 1959</b> , that I last saw the deceased alive on <b>February 11th, 1959</b> , and that death occurred at <b>3:30 a.m.</b> from the causes and on the date stated above.                                                                                                                           |                                     |                                                                                                                                                          |                                                                               |
| ACTUAL SIGNATURE <b>Wyand F. Doerner, Jr.</b> M.D.                                                                                                                                                                                                                                                                                                                                               |                                     | ADDRESS (Street, city or town, state) <b>Algonquin Hotel</b> DATE SIGNED <b>2-17-59</b>                                                                  |                                                                               |
| PHYSICIAN'S NAME (Type) <b>Wyand F. Doerner, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                       |                                     | <b>Cumberland, Maryland.</b>                                                                                                                             |                                                                               |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       | 22b. DATE THEREOF<br><b>2-18-59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>                                                                                          | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Louis Stein</b>                                                                                                                                                                                                                                                                                                                                           |                                     | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                        |                                                                               |
| 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 19 '59</b>                                                                                                                                                                                                                                                                                                                                                |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>                                                                                                     |                                                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1398

CERTIFICATE OF DEATH

Reg. Dist. No.

01379

|                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                          |                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                        |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>                                                                                                                                                                                                                                                                                                                        |                               | c. LENGTH OF STAY IN 1b <b>6 Days</b>                                                                                                                    |                                        |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>                                                                                                                                                                                                                                                                                                                     |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                        |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Annie</b> Middle <b>K.</b> Last <b>Lindsay</b>                                                                                                                                                                                                                                                                                                                           |                               | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>5th</b> Year <b>19 59</b>                                                                               |                                        |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                     | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>May 25th, 1884</b> |
| 9. AGE (In years last birthday) <b>74</b> yrs.                                                                                                                                                                                                                                                                                                                                                                           |                               | 10. IF UNDER 1 YEAR: Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.                                                                                |                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>                                                                                                                                                                                                                                                                                                           |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>                                                                                                   |                                        |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                  |                                        |
| 13. FATHER'S NAME <b>John Lindsay</b>                                                                                                                                                                                                                                                                                                                                                                                    |                               | 14. MOTHER'S MAIDEN NAME <b>Annie King</b>                                                                                                               |                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>                                                                                                                                                                                                                                                                                                                                           |                               | 16. SOCIAL SECURITY NO. <b>None</b>                                                                                                                      |                                        |
| 17. INFORMANT <b>Robert Lindsay, RFD 1, Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                               |                               | Address <b>Box 22</b>                                                                                                                                    |                                        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of abdomen &amp; metastasis</b><br>1992<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) <b>arteriosclerotic cardiac disease</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Feb - 1959</b> |                               |                                                                                                                                                          |                                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic cardiac disease</b>                                                                                                                                                                                                                                                |                               |                                                                                                                                                          |                                        |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                          |                                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                        |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.                                                                                                                                                                                                                                                                                                                                                 |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |                                        |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                   |                               | 20f. (City or town) (County) (State)                                                                                                                     |                                        |
| 21. I certify that I attended the deceased from <b>Nov. 19 57</b> to <b>Feb 5, 19 59</b> , that I last saw the deceased alive on <b>Feb 5, 19 59</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>2 Broadway</b> DATE SIGNED <b>2/6/59</b>                                                                                   |                               |                                                                                                                                                          |                                        |
| ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                              |                               | PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b> <b>Frostburg, Md.</b>                                                                                 |                                        |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                  |                               | 22b. DATE THEREOF <b>2-8-59</b>                                                                                                                          |                                        |
| 22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>                                                                                                                                                                                                                                                                                                                                                            |                               | 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>                                                                                      |                                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                  |                               | ADDRESS <b>9 '59</b>                                                                                                                                     |                                        |
| 24a. REC'D BY REGISTRAR <b>Arthur E. Travis</b>                                                                                                                                                                                                                                                                                                                                                                          |                               | 24b. REGISTRAR'S SIGNATURE                                                                                                                               |                                        |



1305

DATE OF DEATH

1305

Allegheny

Maryland

Allegheny

Prosburn

6 boys

Prosburn

67 Grant Street

Miner's Hospital

1

77

Feb 25th

February 25th

Lindsay

E. X.

Annie

74

May 25th, 1884

White

Female

USA

Maryland

own housework

Housekeeper

Annie King

John Lindsay

Box 23

Robert Lindsay, RFD 1, Prosburn, Md.

None

2 Prosburn

Mo.

Prosburn

John E. Davis, M.D.

Mo.

Prosburn

F. H. Mortimer, M.D.

John H. Gunt, Prosburn, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1368

## CERTIFICATE OF DEATH

01380

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          |                                                            |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                             |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>PENNSYLVANIA</b> b. COUNTY |                                                                          |                                                            |                                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                           | c. LENGTH OF STAY IN 1b <b>22 DAYS</b>                                                                                          |                                                                          |                                                            |                                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                                                                                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                                             |                                                                          |                                                            |                                            |
| 3. NAME OF DECEASED (Type or print)<br>First <b>A</b> Middle <b>ERNEST</b> Last <b>LIVENGOOD</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>FEBRUARY 21</b> Day <b>1959</b>                                              |                                                                                                                                 |                                                                          |                                                            |                                            |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT 14</b>                                                                        |                                                                                                                                 | 9. AGE (In years last birthday) <b>79</b> yrs.                           | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |                                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BANKER-Retired</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>                                                          |                                                                                                                                 | 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>            |                                                            | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>JACOB D LIVENGOOD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH BEACHY</b>                                                                             |                                                                          |                                                            |                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO. <b>NOX E</b>                                                                      |                                                                                                                                 | 17. INFORMANT<br><b>MEMORIAL HOSPITAL CUMBERLAND MARYLAND</b><br>Address |                                                            |                                            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis with myocardial degeneration</b><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign hypertrophy prostate</b> |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          |                                                            | INTERVAL BETWEEN ONSET AND DEATH           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |                                                                                                                                 |                                                                          |                                                            |                                            |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day Year <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                                                                                                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                                            | 20f. (City or town) (County) (State)       |
| 21. I certify that I attended the deceased from <b>2-21-59</b> to <b>2-21-59</b> , that I last saw the deceased alive on <b>2-21-59</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>2-22-59</b>                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          |                                                            |                                            |
| ACTUAL SIGNATURE <b>Howard L. Tolson</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          |                                                            |                                            |
| PHYSICIAN'S NAME (Type) <b>HOWARD L. TOLSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          |                                                            |                                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 22b. DATE THEREOF                                                                                                                                           |                                                                                                           | 22c. NAME OF CEMETERY OR CREMATORY                                                                                              |                                                                          | 22d. LOCATION (City, town, or county) (State)              |                                            |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | <b>Feb. 24-1959</b>                                                                                                                                         |                                                                                                           | <b>Salisbury &amp; Co. F.</b>                                                                                                   |                                                                          | <b>Salisbury, Jones &amp; Co. Penna</b>                    |                                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Stanley M. Thomas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                             |                                                                                                           | ADDRESS<br><b>Salisbury, Pa</b>                                                                                                 |                                                                          | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 27 '59</b>          |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                          | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>      |                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                                       |  |                                          |  |                                          |  |                                             |  |                                     |  |                                     |  |
|---------------------------------------|--|------------------------------------------|--|------------------------------------------|--|---------------------------------------------|--|-------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED<br>JAMES J. JONES    |  | AGE<br>45                                |  | SEX<br>Male                              |  | RACE<br>White                               |  | DATE OF BIRTH<br>July 1, 1910       |  | PLACE OF BIRTH<br>Baltimore, Md.    |  |
| MARRIED<br>Yes                        |  | SINGLE<br>No                             |  | WIDOWED<br>No                            |  | DIVORCED<br>No                              |  | DATE OF MARRIAGE<br>June 15, 1935   |  | PLACE OF MARRIAGE<br>Baltimore, Md. |  |
| OCCUPATION<br>Salesman                |  | EDUCATION<br>High School                 |  | RELIGION<br>Catholic                     |  | MILITARY SERVICE<br>None                    |  | DATE OF DEATH<br>July 15, 1955      |  | PLACE OF DEATH<br>Baltimore, Md.    |  |
| CAUSE OF DEATH<br>Heart Disease       |  | MANNER OF DEATH<br>Natural               |  | IMMEDIATE CAUSE<br>Myocardial Infarction |  | UNDERLYING CAUSE<br>Coronary Artery Disease |  | DATE OF AUTOPSY<br>None             |  | PLACE OF AUTOPSY<br>None            |  |
| SIGNATURE OF PHYSICIAN<br>J. J. Jones |  | SIGNATURE OF FUNERAL HOME<br>J. J. Jones |  | SIGNATURE OF WITNESS<br>J. J. Jones      |  | SIGNATURE OF WITNESS<br>J. J. Jones         |  | SIGNATURE OF WITNESS<br>J. J. Jones |  | SIGNATURE OF WITNESS<br>J. J. Jones |  |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |                                                                                                          |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | c. LENGTH OF STAY IN 1b<br><b>DOA</b>                                                                                                                       |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             | d. STREET ADDRESS<br><b>638 Fayette Street</b>                                                                                              |                                                                                                          | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harold</b> Middle <b>McAtee</b> Last <b>McAtee</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>17,</b> Year <b>19 59</b>                                                                      |                                                                                                          |                                                                                                   |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 8, 1906</b>                                                                                                     | 9. AGE (In years last birthday)<br><b>52</b> yrs.                                                        | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mgr. Rep. &amp; Main.</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Kelly-Springfield</b>                                                                                               |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>Shawtown, Ohio</b>                                       |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 13. FATHER'S NAME<br><b>Binton McAtee</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Mary Harlow</b>                                                                                              |                                                                                                          |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>274-01-2205</b>                                                                                                               |                                                                                                                                             | 17. INFORMANT<br><b>Mrs. Elizabeth McAtee</b> Address <b>638 Fayette Street Cumberland, Maryland</b>     |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion, left</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>*----</b>                                                  |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                                                                                                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town)<br><b>Hoopeston, Illinois</b>                                                                                           | (County) (State)                                                                                         |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                        |                                                                                                                                             | DATE SIGNED                                                                                              |                                                                                                   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |                                                                                                                                             | <b>Feb. 17, 1959</b>                                                                                     |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  | 22b. DATE THEREOF<br><b>2/20/59</b>                                                                       | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Floral Hill Cemetery</b>                                                                                           | 22d. LOCATION (City, town, or county) (State)<br><b>Hoopeston, Illinois</b>                                                                 |                                                                                                          |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br><b>Feb 19 '59</b>                                                                                                |                                                                                                          |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kraus</b>                                                                                       |                                                                                                          |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                        |  |                               |  |                       |  |
|------------------------|--|-------------------------------|--|-----------------------|--|
| Name of Deceased       |  | Sex                           |  | Age                   |  |
| Harold                 |  | Male                          |  | 17                    |  |
| Date of Death          |  | Place of Death                |  | Cause of Death        |  |
| Feb. 17, 1952          |  | Home                          |  | Sudden                |  |
| Time of Death          |  | Occupation                    |  | Manner of Death       |  |
| 10:00 PM               |  | Student                       |  | Natural               |  |
| Signature of Physician |  | Signature of Medical Examiner |  | Signature of Coroner  |  |
| [Signature]            |  | [Signature]                   |  | [Signature]           |  |
| Date of Report         |  | Place of Report               |  | Signature of Reporter |  |
| Feb. 17, 1952          |  | Baltimore                     |  | [Signature]           |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01382

Reg. Dist. No.

1407

|                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                    |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Little Orleans</b>                                                                                                                                                                                                                                                   |                                                                                                           | c. LENGTH OF STAY IN 1b<br><b>75 Yrs</b>                                                                                                                    |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Home</b>                                                                                                                                                                                                                                                                       |                                                                                                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lavannah</b> Middle <b>McDonald</b>                                                                                                                                                                                                                                                                               |                                                                                                           | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>4</b> Year <b>19 59</b>                                                                                           |                                                                                                   |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><b>W</b>                                                                              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6.3.1873</b>                                                               |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>2</b>                                                                                                        | 11. IF UNDER 24 HRS.<br>Hours <b>2</b> Min.                                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                   |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>                                                                                                       |                                                                                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>                                                                                                                                                                                                                                                                                                        |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                                                   |
| 13. FATHER'S NAME<br><b>Harry Clingerman</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>Not Known</b>                                                                                                                |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                   |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |                                                                                                   |
| 17. INFORMANT<br><b>Bertie L McDonald</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                           | Address<br><b>Little Orleans Md.</b>                                                                                                                        |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>old age</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>Cardiac failure</b> |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>6-8 mo</b>                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Osteoarthritis Obesity</b>                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |                                                                                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                          | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town) (County) (State)                                                              |
| 21. I certify that I attended the deceased from <b>Dec. 31</b> , 19 <b>58</b> , to <b>Jan. 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 12</b> , 19 <b>59</b> , and that death occurred at <b>8</b> PM, from the causes and on the date stated above.                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                                                   |
| ACTUAL SIGNATURE <b>Frank B Thomas III M.D.</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                           | ADDRESS (Street, city or town, state) <b>121 High St., Hancock, Md.</b>                                                                                     |                                                                                                   |
| PHYSICIAN'S NAME (Type) <b>Frank B. Thomas, III, MD</b>                                                                                                                                                                                                                                                                                                           |                                                                                                           | DATE SIGNED <b>2/6/59</b>                                                                                                                                   |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        | 22b. DATE THEREOF<br><b>2.7.59</b>                                                                        | 22c. NAME OF CEMETERY OR <del>CEMETERY</del><br><b>Martins Methodist</b>                                                                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Little Orleans Allegany Md.</b>               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Houder J. Thomas Hancock Md</b>                                                                                                                                                                                                                                                                                            |                                                                                                           | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 9 1959</b>                                                                                                           | 24b. REGISTRAR'S SIGNATURE<br><b>Clifford A. Thomas</b>                                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1898

CERTIFICATE OF DEATH

|                                                       |  |                                                       |  |
|-------------------------------------------------------|--|-------------------------------------------------------|--|
| <p>1. Name of deceased: <u>JOHN J. HARRIS</u></p>     |  | <p>2. Sex: <u>Male</u></p>                            |  |
| <p>3. Age: <u>45</u></p>                              |  | <p>4. Date of death: <u>July 15, 1898</u></p>         |  |
| <p>5. Place of death: <u>Home</u></p>                 |  | <p>6. Cause of death: <u>Heart Disease</u></p>        |  |
| <p>7. Occupation: <u>Engineer</u></p>                 |  | <p>8. Residence: <u>1234 Main St.</u></p>             |  |
| <p>9. Name of physician: <u>Dr. J. H. Smith</u></p>   |  | <p>10. Name of undertaker: <u>John Doe</u></p>        |  |
| <p>11. Name of informant: <u>John Harris</u></p>      |  | <p>12. Address of informant: <u>1234 Main St.</u></p> |  |
| <p>13. Signature of physician: <u>[Signature]</u></p> |  | <p>14. Signature of informant: <u>[Signature]</u></p> |  |



## CERTIFICATE OF DEATH

Reg. Dist. No.

01383

1399

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       |                                                                                                                                                          |                                                                              |
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| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                                                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                       | c. LENGTH OF STAY IN 1b<br><b>35 yrs.</b>                                                                                                                |                                                                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>138 E. College Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HENRY</b> Middle <b>McKEE</b> Last <b>McKEE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       | 4. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>21,</b> Year <b>19 59</b>                                                                                   |                                                                              |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE<br><b>white</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 14, 1877</b>                                     |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       | 10. IF UNDER 1 YEAR<br>Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.                                                                              | 11. IF UNDER 24 HRS.<br>Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>machinist</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Livingston Mach.</b>                                                                                             |                                                                              |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                            |                                                                              |
| 13. FATHER'S NAME<br><b>Henry McKee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte McKenzie</b>                                                                                                    |                                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       | 16. SOCIAL SECURITY NO.<br><b>216-22-5358</b>                                                                                                            |                                                                              |
| 17. INFORMANT<br><b>George McKee,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                       | Address<br><b>Cumberland, Md.</b>                                                                                                                        |                                                                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Chronic arteriosclerotic Cardiovascular Disease</b> DUE TO <b>years.</b><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> |                                       |                                                                                                                                                          |                                                                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                               |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                                                              |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       | 20f. (City or town) _____ (County) _____ (State) _____                                                                                                   |                                                                              |
| 21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>Feb 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 28</b> , 19 <b>59</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Broadway,</b> DATE SIGNED <b>2/23/59.</b><br>ACTUAL SIGNATURE <b>John B. Davis,</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b> <b>Frostburg, Md.</b>                                                                                 |                                       |                                                                                                                                                          |                                                                              |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 22b. DATE THEREOF<br><b>2-24-1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>                                                                                         | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Md.</b>       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 25 '59</b>                                                                                                        |                                                                              |
| ADDRESS<br><b>Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                                                                                     |                                                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1393

Allegany

Proctorburg

133 N. College Ave.

HENRY

male

machinist

Henry McKee

35 yrs.

3 yrs. living

133 N. College Ave.

HENRY

July 1, 1887

Madison Ave. Shop

Charlotte McKee

216-22-237 George McKee, Cumberland, Md.

John B. Davis, N. E.

Proctorburg, Md.

2-2-1919 Robert Memorial Park

Proctorburg, Md.

W. B. Lewis, Proctorburg, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G239 3-6-59 et

1400

CERTIFICATE OF DEATH

01384

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |                                                                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport Md</u>                                                |                                                                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Koken, s Nursing Home</u>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | e. STREET ADDRESS <u>1 437 Walnut St</u>                                                                                                                 |                                                                                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>GEORGE W. MORRISON</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 4. DATE OF DEATH Month Day Year<br><u>Feb 26 19 59</u>                                                                                                   |                                                                                  |
| 5. SEX <u>male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE <u>white</u>                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 9 st 1882</u>                                           |
| 9. AGE (In years last birthday) <u>76</u> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | IF UNDER 1 YEAR                                                                                                                                          | IF UNDER 24 HRS.                                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jockey</u>                                                                                                          | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                        |
| 12. CITIZEN OF WHAT COUNTRY? <u>America</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 13. FATHER'S NAME <u>William Morrison</u>                                                                                                                |                                                                                  |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Close</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)                                      |                                                                                  |
| 16. SOCIAL SECURITY NO. <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 17. INFORMANT <u>Dorothy Smith</u> Address <u>Cumberland, Md.</u>                                                                                        |                                                                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Renal Disease.</u><br><u>241X</u> DUE TO <u>Bronchial Asthma.</u><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO <u>Epilepsy petit mal</u><br>(c) <u>20 Yrs</u>                                                                                                                                                     |                                                                                                        |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><u>1yr</u><br><u>10 Yrs</u><br><u>20 Yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                   | 20f. (City or town) (County) (State)                                             |
| 21. I certify that I attended the deceased from <u>Dec 1958</u> , 19 <u>58</u> , to <u>Feb 26</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>59</u> , and that death occurred at <u>7.55</u> M, from the causes and on the date stated above.<br><u>James H Wolverton Sr Md</u><br>ADDRESS (Street, city or town, state) <u>Piedmont W Va</u><br>DATE SIGNED <u>2/27/59</u><br>ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u><br>PHYSICIAN'S NAME (Type) <u>[Signature]</u> |                                                                                                        |                                                                                                                                                          |                                                                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 22b. DATE THEREOF <u>3/1/1959</u>                                                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>                                                                                        | 22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md</u>               |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> ADDRESS <u>Cumberland, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 24a. REC'D BY REGISTRAR <u>MAR 2 '59</u>                                                                                                                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>                                |







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01385

1370

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                |                                                                                                           |                                                                                                                                                          |                                                                                                               |                                                                                                   |                                                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                                                                                               |                                                                                                   |                                                                                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                | c. LENGTH OF STAY IN 1b<br><b>16 Days</b>                                                                 |                                                                                                                                                          | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Cumberland</b> |                                                                                                   |                                                                                                   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sylvan Retreat</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                |                                                                                                           | d. STREET ADDRESS<br><b>Valley Road</b>                                                                                                                  |                                                                                                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jacob</b> Middle <b>Adam</b> Last <b>Nazelrod</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                |                                                                                                           | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>8</b> Year <b>1959</b>                                                                                  |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 6. COLOR OR RACE<br><b>White</b>                               |                                                                                                           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                               | 8. DATE OF BIRTH<br><b>10/6/84</b>                                                                |                                                                                                   |  |
| 9. AGE (In years lost birthday) yrs. <b>74</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                      |                                                                                                           | IF UNDER 24 HRS.                                                                                                                                         |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>                                                 |                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>                                             |                                                                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                     |  |
| 13. FATHER'S NAME<br><b>John Nazelrod</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Cleaver</b>                                                                                                     |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) |                                                                                                           | 17. INFORMANT<br><b>Robert Nazelrod, Rt. 3, Cumberland, Md.</b>                                                                                          |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420 Cerebral Sclerosis -</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422. Myocardial Degeneration</b><br>DUE TO (c) <b>450 General arteriosclerosis.</b>                                                                    |  |                                                                |                                                                                                           |                                                                                                                                                          |                                                                                                               |                                                                                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b><br><b>?</b><br><b>?</b>                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>304 Simple psychosis</b>                                                                                                                                                                                                                                                                                        |  |                                                                |                                                                                                           |                                                                                                                                                          |                                                                                                               |                                                                                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |  |                                                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |                                                                                                                                                          |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |                                                                                                                                                          | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                        |                                                                                                   | 20f. (City or town) (County) (State)                                                              |  |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.<br>ACTUAL SIGNATURE <b>James E. McLean</b> M.D. ADDRESS (Street, city or town, state) <b>49 Greene St. -</b> DATE SIGNED _____<br>PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b> <b>49 Greene Street, Cumberland, Md.</b> |  |                                                                |                                                                                                           |                                                                                                                                                          |                                                                                                               |                                                                                                   |                                                                                                   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 22b. DATE THEREOF<br><b>2/11/59</b>                            |                                                                                                           | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Milam Cemetery</b>                                                                                              |                                                                                                               | 22d. LOCATION (City, town, or county) (State)<br><b>Milam, West Virginia</b>                      |                                                                                                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                |                                                                                                           | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 16 '59</b>                                                                                                        |                                                                                                               | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Hafer</b>                                             |                                                                                                   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01386

1371

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |                                                                                                          |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b>                                                                                                                                                                                                                                                                                                                                                      |                                  | c. LENGTH OF STAY IN 1b<br><b>8 days</b>                                                                                                                    |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02Cumberland,</b> |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sacred Heart Hosp.</b>                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             | d. STREET ADDRESS<br><b>218 S. Smallwood St.,</b>                                                                                           |                                                                                                          | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>Anna May Nesbitt</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>16</b> Year <b>1959</b>                                                                        |                                                                                                          |                                                                                                   |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 20, 1897</b>                                                                                                    |                                                                                                          | 9. AGE (In years last birthday)<br><b>61 yrs.</b>                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>                                                                                                                                                                                                                                                                                                                                                  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                                                                                                      |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>Artemas, Penna.</b>                                      |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             | 13. FATHER'S NAME<br><b>Jesse Diehl</b>                                                                                                     |                                                                                                          |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Riley</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No,</b>                                                            |                                                                                                          |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br><b>212-18-1463</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             | 17. INFORMANT<br><b>Mrs. Ethel Hamilton</b> Address: <b>Cumberland, Md. 218 S. Smallwood St.,</b>                                           |                                                                                                          |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO (b) <b>Fracture of Acetabulum, right</b><br>DUE TO (c) <b>Dislocation of hip, right</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                              |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>8 days</b><br><b>8 days</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Automobile Accident (rt # 56 Near Pleasantville, Pa)</b>                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><b>Automobile Accident (rt # 56 Near Pleasantville, Pa)</b> |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>9:30 p.m. Feb. 8 1959</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                        |                                                                                                                                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>                 |                                                                                                   |
| 20f. (City or town)<br><b>Nr. Pleasantville Bedford</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | 20g. (County)<br><b>Penna.</b>                                                                                                                              |                                                                                                                                             | 20h. (State)<br><b>Penna.</b>                                                                            |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                             |                                                                                                          |                                                                                                   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                         |                                                                                                          |                                                                                                   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             | DATE SIGNED <b>Feb. 16, 1959</b>                                                                                                            |                                                                                                          |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 22b. DATE THEREOF<br><b>2/19/59</b>                                                                                                                         |                                                                                                                                             | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Cem.</b>                                          |                                                                                                   |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                  | 22e. (State)<br><b>Md.</b>                                                                                                                                  |                                                                                                                                             | 22f. (County)<br><b>Allegany</b>                                                                         |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br><b>DATE FEB 18 '59</b>                                                                                           |                                                                                                          |                                                                                                   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             | 24c. (City, town, or county)<br><b>Cumberland, Md.</b>                                                                                      |                                                                                                          |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1980

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1971

FOR STATE  
HEALTH DEPT



1. Name of Deceased: [illegible]  
2. Date of Birth: [illegible]  
3. Sex: [illegible]  
4. Race: [illegible]  
5. Marital Status: [illegible]  
6. Occupation: [illegible]  
7. Usual Residence: [illegible]  
8. Date of Death: [illegible]  
9. Place of Death: [illegible]  
10. Cause of Death: [illegible]  
11. Manner of Death: [illegible]  
12. Signature of Medical Examiner: [illegible]  
13. Date of Certification: [illegible]



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01387

1372

Item 9 Film 6239 3-2-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u><br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baths</u> 0354.2 |                                                                                            |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Timberland Md.</u>                                                                                                                                                                                                                                                                                                                                        |                                  | c. LENGTH OF STAY IN 1b<br><u>6 Mo.</u>                                                                                                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 21, Maryland</u>                               |                                                                                            |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sacred Heart Hosp.</u>                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             | d. STREET ADDRESS<br><u>109 Hampshire Rd.</u>                                                                                                   |                                                                                            | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Frank</u> Middle <u>E</u> Last <u>Nichols</u>                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>23</u> Year <u>1959</u>                                                                            |                                                                                            |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 7, 1921</u>                                                                                                         |                                                                                            | 9. AGE (In years last birthday)<br><u>38</u> 37                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Construction Worker</u>                                                                                                                                                                                                                                                                                                                        |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hazelwood Co.</u>                                                                                                   |                                                                                                                                                 | 11. BIRTH PLACE (State or foreign country)<br><u>Roanoke Va.</u>                           |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                             | 13. FATHER'S NAME<br><u>George H. Nichols</u>                                                                                                   |                                                                                            |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><u>Ruth Bennett</u>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u> <u>Marius</u>                                                  |                                                                                            |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br><u>Marius</u>                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |                                                                                                                                                             | 17. INFORMANT<br><u>County Medical Examiner</u>                                                                                                 |                                                                                            |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemopneumothorax, left</u><br><u>825x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest, left</u><br>(a), stating the underlying cause last. DUE TO (c)                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                     |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Automobile Accident</u>                                  |                                                                                                                                                 |                                                                                            |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>6:00</u> <u>Feb. 23</u> 1959                                                                                                                                                                                                                                                                                                                                                             |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                        |                                                                                                                                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Rt. # 220</u> |                                                                                                   |
| 20f. (City or town)<br><u>Near Rawlings, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | (County) <u>Alleg. Md.</u> (State)                                                                                                                          |                                                                                                                                                 |                                                                                            |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u>                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | M.D.                                                                                                                                                        |                                                                                                                                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                            |                                                                                                   |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                                                                                                                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                        |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                                                                                                                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 23, 1959</u>           |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 22b. DATE THEREOF<br><u>2/25/59</u>                                                                                                                         |                                                                                                                                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greenlawn Cem.</u>                                |                                                                                                   |
| 22d. LOCATION (City, town, or county)<br><u>Roanoke Va.</u>                                                                                                                                                                                                                                                                                                                                                                                      |                                  | (State)                                                                                                                                                     |                                                                                                                                                 |                                                                                            |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Stein Inc</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                  | ADDRESS<br><u>Cumb. Md.</u>                                                                                                                                 |                                                                                                                                                 | 24a. REC'D BY REGISTRAR<br><u>FEB 26 '59</u>                                               |                                                                                                   |
| 24b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                                                            |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





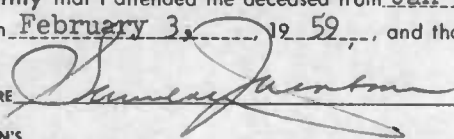



1373

## CERTIFICATE OF DEATH

01388

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b><br>c. LENGTH OF STAY IN 1b<br><b>25 DAYS</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                 |  |                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>ALLEGANY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b><br>d. STREET ADDRESS<br><b>112 N. SMALLWOOD ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                        |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ADA Blanche PARKER</b>                                                                                                                                                                                                                                                                                                                                   |  |                                           |  | 4. DATE OF DEATH<br>Month Day Year<br><b>FEB. 4, 19 59</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. COLOR OR RACE<br><b>WHITE</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                            |  | 8. DATE OF BIRTH<br><b>MARCH 31, 1885</b>                              |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.                                                                                                                                                                                                                                                                                                                                                                       |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                         |  |                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                                                                                                                                                                                                                                                                                                                |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hazen, Md.</b>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |
| 13. FATHER'S NAME<br><b>CLARENCE CLITES (DECEASED)</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Welsh (DECEASED)</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>                                                                                                                                                                                                                                                                                                 |  |                                           |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |
| 17. INFORMANT<br><b>Mr. George C. Parker McMullen Hwy. Cumb.</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                           |  | Address                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute/ventricular failure</b><br>420.1<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Myocardial fibrosis with decompensation</b><br>4 weeks<br>(c) <b>Coronary arteriosclerosis, left ventricular phytrophy ?</b> |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>Uremia and attack of acute left ventricular failure, 1 week ago.</b>                                                                                                             |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      |  |                                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                                                                                                                                                                        |  |                                                                        |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.                                                                                                                                                                                                                                                                                                                                                             |  |                                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                           |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                           |  | (County)                                                                                                                                                                                                                                                                                                                                                                                                            |  | (State)                                                                |  |
| 21. I certify that I attended the deceased from <b>Jan 9, 19 59</b> , to <b>Feb. 4, 19 59</b> , that I last saw the deceased alive on <b>February 3, 19 59</b> , and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>50 Pershing St., Cumberland, Md.</b><br>DATE SIGNED <b>2/5/59</b>                                                |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |
| ACTUAL SIGNATURE <br>PHYSICIAN'S NAME (Type) <b>Samuel Jacobson, M.D.</b>                                                                                                                                                                                                                                                            |  |                                           |  | DATE SIGNED <b>2/5/59</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                        |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                           |  | 22b. DATE THEREOF<br><b>2/7/59</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>      |  |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                           |  | (State)                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                           |  | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 24a. REC'D BY REGISTRAR<br><b>FEB 9 '59</b>                            |  |
| 24b. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                     |  |                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1912

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

NAME OF REGISTRAR

DATE OF REGISTRATION

NAME OF WITNESS

DATE OF WITNESS

NAME OF WITNESS

DATE OF WITNESS

NAME OF WITNESS

DATE OF WITNESS

NAME OF WITNESS

DATE OF WITNESS



1374

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                      |  |                                                                                                                                                          |  |                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                            |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |                                                                           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>                                                                                                                                                                                                                                                                        |  |                                      |  | c. LENGTH OF STAY IN lb <b>30 DAYS</b>                                                                                                                   |  |                                                                           |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                                 |  |                                      |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  |                                                                           |  |
| 3. NAME OF DECEASED (Type or print) <b>AMANDA Marie</b>                                                                                                                                                                                                                                                                                                                   |  |                                      |  | 4. DATE OF DEATH <b>PERSCH FEB 5 19 59</b>                                                                                                               |  |                                                                           |  |
| 5. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                      |  | 6. COLOR OR RACE <b>WHITE</b>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1890 FEB. 1, 1888</b>                                 |  |
| 9. AGE (In years last birthday) <b>69</b>                                                                                                                                                                                                                                                                                                                                 |  | 10. IF UNDER 1 YEAR <b>xx</b> Months |  | 11. IF UNDER 24 HRS. <b>xx</b> Days                                                                                                                      |  | 12. IF UNDER 24 HRS. <b>xx</b> Hours                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>                                                                                                                                                                                                                                                              |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  |                                                                           |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND Cumberland</b>                                                                                                                                                                                                                                                                                                      |  |                                      |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                  |  |                                                                           |  |
| 13. FATHER'S NAME <b>CHARLES ROSENMERKLE (DECEASED)</b>                                                                                                                                                                                                                                                                                                                   |  |                                      |  | 14. MOTHER'S MAIDEN NAME <b>BARBARALAYMAN (DECEASED)</b>                                                                                                 |  |                                                                           |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>                                                                                                                                                                                                                                                                             |  | 16. SOCIAL SECURITY NO. <b>none</b>  |  | 17. INFORMANT <b>PATIENT'S CHART</b>                                                                                                                     |  |                                                                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>15 years</b><br><b>10 years</b> |  |                                      |  |                                                                                                                                                          |  |                                                                           |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                         |  |                                      |  |                                                                                                                                                          |  |                                                                           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |  |                                                                           |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                        |  |                                      |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town) (County) (State)                                                                                                                                                                                                                                                                                                                                      |  |                                      |  | 20g. (City or town) (County) (State)                                                                                                                     |  |                                                                           |  |
| 21. I certify that I attended the deceased from <b>44</b> to <b>2-5-1959</b> that I last saw the deceased alive on <b>2-4-1959</b> and that death occurred at <b>929A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>16 Greene St., Cumberland, Md.</b> DATE SIGNED <b>2-5-59</b>                                       |  |                                      |  |                                                                                                                                                          |  |                                                                           |  |
| ACTUAL SIGNATURE <b>James T. Johnson, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                       |  |                                      |  | PHYSICIAN'S NAME (Type) <b>James T. Johnson, Jr., M.D.</b>                                                                                               |  |                                                                           |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                   |  | 22b. DATE THEREOF <b>2/7/59</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>                                                                                            |  | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                               |  |                                      |  | 24a. REC'D BY REGISTRAR <b>FEB 11 1959</b>                                                                                                               |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01390

Reg. Dist. No.

1375

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                                    |                                                                                                                                             |                                                                                                                        |                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |                                                                                                                        |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | c. LENGTH OF STAY IN <b>1b</b><br><b>years</b>                                                                                                                     |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>129 Maple Street Cumberland</b> |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>129 Maple Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                                    | d. STREET ADDRESS<br><b>129 Maple Street</b>                                                                                                |                                                                                                                        | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>John Hugh Reuschel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                                    | 4. DATE OF DEATH<br><b>Feb. 28 1959</b>                                                                                                     |                                                                                                                        |                                                                                                   |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> | 8. DATE OF BIRTH<br><b>June 12, 1898</b>                                                                                                    |                                                                                                                        | 9. AGE (In years last birthday)<br><b>60 yrs.</b>                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self Employed</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>                                                                                                              |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Maryland</b>                                               |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                                    | 13. FATHER'S NAME<br><b>John Reuschel</b>                                                                                                   |                                                                                                                        |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><b>Anna Hartung</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                             |                                                                                                                        |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                                    | 17. INFORMANT<br><b>Mrs. Raymond Snyder</b>                                                                                                 |                                                                                                                        |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |                                  |                                                                                                                                                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                           |                                                                                                                        |                                                                                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                       |                                                                                                                                             |                                                                                                                        |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                          |                                                                                                                                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                 |                                                                                                   |
| 20f. (City or town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 20g. (County) (State)                                                                                                                                              |                                                                                                                                             |                                                                                                                        |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                    |                                  |                                                                                                                                                                    |                                                                                                                                             |                                                                                                                        |                                                                                                   |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  | M.D.                                                                                                                                                               |                                                                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                        |                                                                                                   |
| EXAMINER'S NAME (Type)<br><b>Benedict Skitarelic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                        |                                                                                                                                             | DATE SIGNED<br><b>Feb. 28, 1959</b>                                                                                    |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 22b. DATE THEREOF<br><b>March 2, 1959</b>                                                                                                                          |                                                                                                                                             | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Lutheran Cemetery</b>                                                 |                                                                                                   |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | 22e. (State)                                                                                                                                                       |                                                                                                                                             |                                                                                                                        |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                    | ADDRESS                                                                                                                                     |                                                                                                                        | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 3 '59</b>                                                  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hafer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                                    |                                                                                                                                             |                                                                                                                        |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Date of Death: \_\_\_\_\_

9. Time of Death: \_\_\_\_\_

10. Signature of Medical Examiner: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Registrar: \_\_\_\_\_

13. Signature of Physician: \_\_\_\_\_

14. Signature of Nurse: \_\_\_\_\_

15. Signature of Undertaker: \_\_\_\_\_

16. Signature of Burial Place: \_\_\_\_\_

17. Signature of Funeral Home: \_\_\_\_\_

18. Signature of Cemetery: \_\_\_\_\_

19. Signature of Interment: \_\_\_\_\_

20. Signature of Burial: \_\_\_\_\_

21. Signature of Cremation: \_\_\_\_\_

22. Signature of Disposition: \_\_\_\_\_

23. Signature of Final Disposition: \_\_\_\_\_

24. Signature of Final Disposition: \_\_\_\_\_

25. Signature of Final Disposition: \_\_\_\_\_

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01391

1376

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                      |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |                                                                                                          |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                      | c. LENGTH OF STAY IN 1b<br><u>30 yrs.</u>                                                                                                                   |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u> |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Williams Road</u>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                      |                                                                                                                                                             | d. STREET ADDRESS<br><u>209 Mary St.</u>                                                                                                    |                                                                                                          | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Thomas</u> Middle <u>W</u> Last <u>Rice</u>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                      |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>26</u> Year <u>19 59</u>                                                                       |                                                                                                          |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><u>White</u>                                                                                     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 5, 1912</u>                                                                                                     |                                                                                                          | 9. AGE (in years last birthday)<br><u>46</u> yrs.                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Boilermaker Inspector Railroad</u>                                                                                                                                                                                                                                                                                                                        |                                                                                                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Boyd Station, Md.</u>                                                                                               |                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><u>USA</u>                                                  |                                                                                                   |
| 13. FATHER'S NAME<br><u>Maurice W. Rice</u>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                      |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Ethel Vera Simpson</u>                                                                                       |                                                                                                          |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      | 16. SOCIAL SECURITY NO.<br><u>no</u>                                                                                                                        |                                                                                                                                             | 17. INFORMANT<br><u>Mrs. Maurice W. Rice, Cumberland, Md.</u>                                            |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxiation</u><br><u>973.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Carbon Monoxide Poisoning</u><br>(a), stating the underlying cause lost. DUE TO (c)                                                                                                                            |                                                                                                                      |                                                                                                                                                             |                                                                                                                                             |                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><u>10-15 Min.</u><br><u>10-15 Min.</u>                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                                      |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                |                                                                                                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Suicide (Auto gas inhalation)</u>                        |                                                                                                                                             |                                                                                                          |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>Feb. 26 1959</u><br>Hour <u>10</u> p. m.                                                                                                                                                                                                                                                                                                                                                                      | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Suicide</u>                                                                    |                                                                                                                                             | 20f. (City or town) (County) (State)<br><u>Cumberland, Alleg. Md.</u>                                    |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                                      |                                                                                                                                                             |                                                                                                                                             |                                                                                                          |                                                                                                   |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                      | M.D.                                                                                                                                                        |                                                                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                          |                                                                                                   |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |                                                                                                                                             | DATE SIGNED <u>Feb. 27, 1959</u>                                                                         |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                  | 22b. DATE THEREOF<br><u>3-2-1959</u>                                                                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Memorial Park</u>                                                                                           |                                                                                                                                             | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Md.</u>                                  |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>James F. Scarpelli, Cumberland, Md.</u>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                      | ADDRESS                                                                                                                                                     |                                                                                                                                             | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 2 '59</u>                                                         |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      |                                                                                                                                                             |                                                                                                                                             | 24b. REGISTRAR'S SIGNATURE<br><u>Charles L. Knoch</u>                                                    |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1401

CERTIFICATE OF DEATH

Reg. Dist. No.

01392

|                                                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                             |                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                      |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                        |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>                                                                                                                                                                                                                                            |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>                                                          |                                        |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>                                                                                                                                                                                                                                          |                               | d. STREET ADDRESS <b>Jackson Street</b>                                                                                                                     |                                        |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>RICHMOND</b> Last <b>RICHMOND</b>                                                                                                                                                                                                                                        |                               | 4. DATE OF DEATH<br>Month <b>Feb</b> Day <b>20th.</b> Year <b>19 59</b>                                                                                     |                                        |
| 5. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                           | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 8th 1894</b> |
| 9. AGE (In years last birthday) <b>64</b> yrs.                                                                                                                                                                                                                                                                                               |                               | IF UNDER 1 YEAR Months Days Hours Min.                                                                                                                      |                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed Grocery Business</b>                                                                                                                                                                                                            |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing</b>                                                                                                         |                                        |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>                                                                                                                                                                                                                                                                                      |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                  |                                        |
| 13. FATHER'S NAME <b>William Richmond</b>                                                                                                                                                                                                                                                                                                    |                               | 14. MOTHER'S MAIDEN NAME <b>Hannah Lynch</b>                                                                                                                |                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes World War # 1</b>                                                                                                                                                                                                                                                  |                               | 16. SOCIAL SECURITY NO. <b>220-10-1774</b>                                                                                                                  |                                        |
| 17. INFORMANT <b>Mrs. Estella Richmond, (WIFE)</b>                                                                                                                                                                                                                                                                                           |                               | Address <b>Lonaconing, MD.</b>                                                                                                                              |                                        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Angina Pectoris</b><br>DUE TO (c) <b>Arteriosclerosis</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>none</b><br><b>18 mos.</b><br><b>years</b>                                                                           |                                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                            |                               |                                                                                                                                                             |                                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                           |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                        |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                           |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                        |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                       |                               | 20f. (City or town) (County) (State)                                                                                                                        |                                        |
| 21. I certify that I attended the deceased from <b>August, 19 56</b> , to <b>Feb. 20, 19 59</b> , that I last saw the deceased alive on <b>Feb. 19, 19 59</b> , and that death occurred at <b>8:30 a. m.</b> , from the causes and on the date stated above.                                                                                 |                               |                                                                                                                                                             |                                        |
| ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.                                                                                                                                                                                                                                                                                             |                               | ADDRESS (Street, city or town, state) <b>Main St. Lonaconing Md.</b>                                                                                        |                                        |
| PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR</b>                                                                                                                                                                                                                                                                                            |                               | DATE SIGNED <b>2-21-59</b>                                                                                                                                  |                                        |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                      |                               | 22b. DATE THEREOF <b>2/20/1959</b>                                                                                                                          |                                        |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>                                                                                                                                                                                                                                                                                 |                               | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, MD.</b>                                                                                        |                                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>                                                                                                                                                                                                                                                                                      |                               | ADDRESS <b>LONA CONING, MD.</b>                                                                                                                             |                                        |
| 24a. REC'D BY REGISTRAR <b>DATE FEB 25 '59</b>                                                                                                                                                                                                                                                                                               |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                                                                                                           |                                        |







1377

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                          |                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | c. LENGTH OF STAY IN 1b<br><b>9/21/57</b>                                                                                                                |                                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | e. STREET ADDRESS<br><b>230 Glen Street</b>                                                                                                              |                                            |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>M.</b> Last <b>Ridgely</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>14</b> , Year <b>19 59</b>                                                                              |                                            |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/14/1885</b>      |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - R.R. Engineer</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                                                                                                     |                                            |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ridgely, W. Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                          |                                            |
| 13. FATHER'S NAME<br><b>Charles M. Ridgely</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Banner I. Brant</b>                                                                                                       |                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No,</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-22-6275</b>                                                                                                            |                                            |
| 17. INFORMANT<br><b>P.O.Box 599</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | Address <b>Cumberland, Md.</b>                                                                                                                           |                                            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General Hemorrhage</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b><br>(c) <b>Senile arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Prostatitis</b> |                                  |                                                                                                                                                          |                                            |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                          |                                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                       |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                            |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                                |                                            |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  | 20f. (City or town) (County) (State)                                                                                                                     |                                            |
| 21. I certify that I attended the deceased from <b>9/21/57</b> , 19__, to <b>2/14/59</b> , 19__, that I last saw the deceased alive on <b>2/14/59</b> , 19__, and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Greene Street</b> DATE SIGNED <b>2/16/59</b>                                                                                                                                                                      |                                  |                                                                                                                                                          |                                            |
| ACTUAL SIGNATURE <b>James E. McLean</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>                                                                                                       |                                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | 22b. DATE THEREOF<br><b>2/17/59</b>                                                                                                                      |                                            |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                                                                                  |                                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                        |                                            |
| 24a. REC'D BY REGISTRAR<br><b>FEB 18 59</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thau</b>                                                                                                      |                                            |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

SEX

PLACE OF BIRTH

DATE OF DEATH

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PLACE OF BIRTH

DATE OF DEATH

SEX



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01394

1402

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                  | c. LENGTH OF STAY IN 1b<br><b>5 days</b>                                                                                                                    |                                          |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miners Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                              |                                          |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VINCENT</b> Middle <b>ISADORE</b> Last <b>RIEG</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>14,</b> Year <b>19 59</b>                                                                                      |                                          |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 21, 1877</b> |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                               |                                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Mach.Rigger</b>                                                                                                                                                                                                                                                                                                                                                                   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Celanese Corp.</b>                                                                                                  |                                          |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                          |
| 13. FATHER'S NAME<br><b>Michael Rieg</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Carolyn Miller</b>                                                                                                           |                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-05-7096</b>                                                                                                               |                                          |
| INFORMANT<br><b>Bernard Harden, Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  | Address                                                                                                                                                     |                                          |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma 1st part of</b><br><b>153.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) <b>Ascending Colon.</b><br>(c) <b>Severe Arterio-sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b>                                                                    |                                  |                                                                                                                                                             |                                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Senility</b>                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                             |                                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                          |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                          |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                          |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | 20f. (City or town) (County) (State)                                                                                                                        |                                          |
| 21. I certify that I attended the deceased from <b>2-6</b> , 19 <b>59</b> , to <b>2-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-14</b> , 19 <b>59</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>W. Main St.,</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>H. C. Diehl,</b> M.D. <b>W. Main St.,</b><br>PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M. D.</b> <b>Frostburg, Md.</b> |                                  |                                                                                                                                                             |                                          |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 22b. DATE THEREOF<br><b>Feb. 17 '59</b>                                                                                                                     |                                          |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Johnson Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Garrett County, Md.</b>                                                                                 |                                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | 24a. REC'D BY REGISTRAR<br><b>FEB 18 '59</b>                                                                                                                |                                          |
| ADDRESS<br><b>Frostburg, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Harris</b>                                                                                                       |                                          |



1202

CERTIFICATE OF DEATH

Allegany

Marshall

John

Proctor

Western Hospital

VINCENT

ISAACSON

WILCOX

Oct. 21, 1937

White

Hatted-Mach, Roger, German Corp.

Marshall

Michael Riser

Carolyn Miller

213-05-7000 Baltimore Harbor, Frederick, Md.

W. G. Riser, N. D.

Frederick, Md.

Feb. 12, 1938

Johnson Cemetery

Garrett County, Md.

Frederick, Md.

J. H. Riser



# Item 8 FilmG239 3-4-59 et

1378

## CERTIFICATE OF DEATH

Reg. Dist. No.

01395

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                        |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Allegany</b>              |  |                                                                        |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | c. LENGTH OF STAY IN 1b<br><b>10 Days</b>                                                                                                                   |  |                                                                        |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>                                                                                                                                                                                                                                                                       |  |                                                                                                           |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  |                                                                        |                                                                                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>F.</b> Last <b>Robertson</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>27th</b> Year <b>19 59</b>                                                                                 |  |                                                                        |                                                                                                   |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                              |  | 6. COLOR OR RACE<br><b>White</b>                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-8 1909/ 1882</b>                              |                                                                                                   |
| 9. AGE (In years lost birthday)<br><b>76</b> yrs.                                                                                                                                                                                                                                                                                                                                  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                 |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Miner</b>                                          |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 13. FATHER'S NAME<br><b>Joseph- Deceased</b>                                                                                                                |  |                                                                        |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><b>Emilia Foote, Robertson</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                      |  |                                                                        |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 17. INFORMANT<br><b>Pt's Chart</b>                                                                                                                          |  |                                                                        |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Tuberculosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>008X</b><br>DUE TO (c)                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                        | INTERVAL BETWEEN ONSET AND DEATH                                                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                        | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |                                                                                                                                                             |  |                                                                        |                                                                                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.                                                                                                                                                                                                                                                                                                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      |  | 20f. (City or town) (County) (State)                                   |                                                                                                   |
| 21. I certify that I attended the deceased from <b>Feb. 17</b> , 19 <b>59</b> , to <b>2-27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-26</b> , 19 <b>59</b> , and that death occurred at <b>8:40 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>156 N. Centre Street, Cumberland Md.</b><br>DATE SIGNED |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                        |                                                                                                   |
| ACTUAL SIGNATURE <b>Geo. H. Ley, Jr.</b> M.D.                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | PHYSICIAN'S NAME (Type) <b>Dr. L. H. Ley, M.D.</b>                                                                                                          |  |                                                                        |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  | 22b. DATE THEREOF<br><b>3/1/1959</b>                                                                      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>                                                                                                  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, MD.</b> |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>GEORGE EICHHOEN</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | ADDRESS<br><b>LONACONING, MD.</b>                                                                                                                           |  | 24a. REC'D BY REGISTRAR<br><b>MAR 2 59</b><br>DATE                     |                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. P. P.</b>                                                                                                       |  |                                                                        |                                                                                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1938

|                           |  |                            |  |                          |  |                                   |  |
|---------------------------|--|----------------------------|--|--------------------------|--|-----------------------------------|--|
| 1. Name of deceased       |  | 2. Sex                     |  | 3. Age                   |  | 4. Date of death                  |  |
| 5. Place of death         |  | 6. Cause of death          |  | 7. Manner of death       |  | 8. Signature of physician         |  |
| 9. Signature of registrar |  | 10. Signature of informant |  | 11. Signature of witness |  | 12. Signature of funeral director |  |
| 13. Signature of coroner  |  | 14. Signature of jury      |  | 15. Signature of jury    |  | 16. Signature of jury             |  |
| 17. Signature of jury     |  | 18. Signature of jury      |  | 19. Signature of jury    |  | 20. Signature of jury             |  |
| 21. Signature of jury     |  | 22. Signature of jury      |  | 23. Signature of jury    |  | 24. Signature of jury             |  |
| 25. Signature of jury     |  | 26. Signature of jury      |  | 27. Signature of jury    |  | 28. Signature of jury             |  |
| 29. Signature of jury     |  | 30. Signature of jury      |  | 31. Signature of jury    |  | 32. Signature of jury             |  |
| 33. Signature of jury     |  | 34. Signature of jury      |  | 35. Signature of jury    |  | 36. Signature of jury             |  |
| 37. Signature of jury     |  | 38. Signature of jury      |  | 39. Signature of jury    |  | 40. Signature of jury             |  |
| 41. Signature of jury     |  | 42. Signature of jury      |  | 43. Signature of jury    |  | 44. Signature of jury             |  |
| 45. Signature of jury     |  | 46. Signature of jury      |  | 47. Signature of jury    |  | 48. Signature of jury             |  |
| 49. Signature of jury     |  | 50. Signature of jury      |  | 51. Signature of jury    |  | 52. Signature of jury             |  |
| 53. Signature of jury     |  | 54. Signature of jury      |  | 55. Signature of jury    |  | 56. Signature of jury             |  |
| 57. Signature of jury     |  | 58. Signature of jury      |  | 59. Signature of jury    |  | 60. Signature of jury             |  |
| 61. Signature of jury     |  | 62. Signature of jury      |  | 63. Signature of jury    |  | 64. Signature of jury             |  |
| 65. Signature of jury     |  | 66. Signature of jury      |  | 67. Signature of jury    |  | 68. Signature of jury             |  |
| 69. Signature of jury     |  | 70. Signature of jury      |  | 71. Signature of jury    |  | 72. Signature of jury             |  |
| 73. Signature of jury     |  | 74. Signature of jury      |  | 75. Signature of jury    |  | 76. Signature of jury             |  |
| 77. Signature of jury     |  | 78. Signature of jury      |  | 79. Signature of jury    |  | 80. Signature of jury             |  |
| 81. Signature of jury     |  | 82. Signature of jury      |  | 83. Signature of jury    |  | 84. Signature of jury             |  |
| 85. Signature of jury     |  | 86. Signature of jury      |  | 87. Signature of jury    |  | 88. Signature of jury             |  |
| 89. Signature of jury     |  | 90. Signature of jury      |  | 91. Signature of jury    |  | 92. Signature of jury             |  |
| 93. Signature of jury     |  | 94. Signature of jury      |  | 95. Signature of jury    |  | 96. Signature of jury             |  |
| 97. Signature of jury     |  | 98. Signature of jury      |  | 99. Signature of jury    |  | 100. Signature of jury            |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1379

1379

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01396

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                                                                                                                                          |                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |                                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | c. LENGTH OF STAY IN 1b <u>14 days</u>                                                                                                                   |                                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                       |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>EARL</u> Last <u>Robinson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               | 4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>19 59</u>                                                                                          |                                                       |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/6/94</u>                        |
| 9. AGE (In years last birthday) <u>65</u> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Helper</u>                                          | 11. BIRTHPLACE (State or foreign country) <u>W.Va</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 13. FATHER'S NAME <u>Mose Robinson</u>                                                                                                                   |                                                       |
| 14. MOTHER'S MAIDEN NAME <u>Mary Malone</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)                                      |                                                       |
| 16. SOCIAL SECURITY NO. <u>220-10-2238</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 17. INFORMANT <u>Mrs. Earl Robinson, Oldtown, Md.</u> Address                                                                                            |                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u><br>DUE TO (b) <u>Rheumatic Carditis</u><br>DUE TO (c) <u>Cardiac Decompensation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u><br>20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>Feb. 21, 1959</u> , that I last saw the deceased alive on <u>Feb. 21, 1959</u> , and that death occurred at <u>10:10AM</u> , from the causes and on the date stated above.<br>ACTUAL SIGNATURE <u>Clay S. Durrett</u> M.D. ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>2/23/59</u><br>PHYSICIAN'S NAME (Type) <u>Dr. C. E. Durrett</u> <u>236 Virginia Ave.</u><br>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>22b. DATE THEREOF <u>Feb. 24, 1959</u><br>22c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u><br>22d. LOCATION (City, town, or county) (State) <u>Oldtown, Md.</u><br>23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George,</u> ADDRESS <u>Cumberland, Md.</u><br>24a. REC'D BY REGISTRAR DATE <u>FEB 25 '59</u><br>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |                               |                                                                                                                                                          |                                                       |







## CERTIFICATE OF DEATH

1380

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                         |  |                                                                                                       |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                                                     |  |                                                                                                   |  |                                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>                                                                                                                                                                                                                                                                       |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b> |  | c. LENGTH OF STAY IN 1b<br><b>20 Days</b>                                                                                                                                                                                                                                                                |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>ALLEGANY</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b>                                                                            |  | d. STREET ADDRESS<br><b>623 LINCOLN STREET</b>                                                    |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>CATHERINE M. SILLS</b>                                                                                                                                                                                                                                |  | 4. DATE OF DEATH<br>Month Day Year<br><b>FEBRUARY 28 19 59</b>                                        |  | 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                  |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                                                                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  | 8. DATE OF BIRTH<br><b>JULY 9, 1868</b>                                                           |  | 9. AGE (In years last birthday)<br><b>90</b> yrs.                                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                         |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                      |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |  | 13. FATHER'S NAME<br><b>WILLIAM SCHAFER (D)</b>                                                                                                                                     |  | 14. MOTHER'S MAIDEN NAME<br><b>SOPHIA SCHULTZ (D)</b>                                             |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                   |  |
| 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                                                                                                                                                                  |  | 17. INFORMANT<br><b>CHART</b>                                                                         |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of bladder</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 days</b>                                                                                                   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerotic heart disease</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                                                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)          |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                       |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                              |  | 20f. (City or town) (County) (State)                                                              |  |                                                                                                   |  |
| 21. I certify that I attended the deceased from <b>Feb 8, 19 59</b> to <b>Feb 28, 19 59</b> , that I last saw the deceased alive on <b>Feb 28, 19 59</b> , and that death occurred at <b>4:05 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>3-1-59</b> |  |                                                                                                       |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                                                     |  |                                                                                                   |  |                                                                                                   |  |
| ACTUAL SIGNATURE <b>William P. James</b> M.D.                                                                                                                                                                                                                                                                           |  |                                                                                                       |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                                                     |  |                                                                                                   |  |                                                                                                   |  |
| PHYSICIAN'S NAME (Type) <b>W.P. JAMES, M.D.</b> <b>441 N. CENTER STREET CUMBERLAND, Md.</b>                                                                                                                                                                                                                             |  |                                                                                                       |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                                                     |  |                                                                                                   |  |                                                                                                   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                               |  | 22b. DATE THEREOF                                                                                     |  | 22c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                       |  | 22d. LOCATION (City, town, or county) (State)                                                                                                        |  | 23. FUNERAL DIRECTOR'S SIGNATURE                                                                                                                                                    |  | ADDRESS                                                                                           |  |                                                                                                   |  |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                           |  | <b>Mar 3, 1959</b>                                                                                    |  | <b>St. Lukes Cem</b>                                                                                                                                                                                                                                                                                     |  | <b>Cumberland Md</b>                                                                                                                                 |  | <b>James H. Inc. Cumb Md</b>                                                                                                                                                        |  | <b>441 N. CENTER STREET CUMBERLAND, Md.</b>                                                       |  |                                                                                                   |  |
| 24a. REC'D BY REGISTRAR                                                                                                                                                                                                                                                                                                 |  | 24b. REGISTRAR'S SIGNATURE                                                                            |  | 24c. REC'D BY REGISTRAR                                                                                                                                                                                                                                                                                  |  | 24d. REGISTRAR'S SIGNATURE                                                                                                                           |  | 24e. REC'D BY REGISTRAR                                                                                                                                                             |  | 24f. REGISTRAR'S SIGNATURE                                                                        |  |                                                                                                   |  |
| <b>MAR 3 '59</b>                                                                                                                                                                                                                                                                                                        |  | <b>Arthur S. H.</b>                                                                                   |  | <b>MAR 3 '59</b>                                                                                                                                                                                                                                                                                         |  | <b>Arthur S. H.</b>                                                                                                                                  |  | <b>MAR 3 '59</b>                                                                                                                                                                    |  | <b>Arthur S. H.</b>                                                                               |  |                                                                                                   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                            |  |                              |  |                               |  |
|----------------------------|--|------------------------------|--|-------------------------------|--|
| 1. Name of deceased        |  | 2. Sex                       |  | 3. Age                        |  |
| 4. Date of death           |  | 5. Time of death             |  | 6. Place of death             |  |
| 7. Cause of death          |  | 8. Manner of death           |  | 9. Signature of physician     |  |
| 10. Signature of registrar |  | 11. Date of registration     |  | 12. Place of registration     |  |
| 13. Name of informant      |  | 14. Relationship to deceased |  | 15. Signature of informant    |  |
| 16. Name of funeral home   |  | 17. Address of funeral home  |  | 18. Signature of funeral home |  |
| 19. Name of cemetery       |  | 20. Address of cemetery      |  | 21. Signature of cemetery     |  |
| 22. Name of undertaker     |  | 23. Address of undertaker    |  | 24. Signature of undertaker   |  |
| 25. Name of physician      |  | 26. Address of physician     |  | 27. Signature of physician    |  |
| 28. Name of registrar      |  | 29. Address of registrar     |  | 30. Signature of registrar    |  |
| 31. Name of informant      |  | 32. Address of informant     |  | 33. Signature of informant    |  |
| 34. Name of funeral home   |  | 35. Address of funeral home  |  | 36. Signature of funeral home |  |
| 37. Name of cemetery       |  | 38. Address of cemetery      |  | 39. Signature of cemetery     |  |
| 40. Name of undertaker     |  | 41. Address of undertaker    |  | 42. Signature of undertaker   |  |
| 43. Name of physician      |  | 44. Address of physician     |  | 45. Signature of physician    |  |
| 46. Name of registrar      |  | 47. Address of registrar     |  | 48. Signature of registrar    |  |
| 49. Name of informant      |  | 50. Address of informant     |  | 51. Signature of informant    |  |
| 52. Name of funeral home   |  | 53. Address of funeral home  |  | 54. Signature of funeral home |  |
| 55. Name of cemetery       |  | 56. Address of cemetery      |  | 57. Signature of cemetery     |  |
| 58. Name of undertaker     |  | 59. Address of undertaker    |  | 60. Signature of undertaker   |  |
| 61. Name of physician      |  | 62. Address of physician     |  | 63. Signature of physician    |  |
| 64. Name of registrar      |  | 65. Address of registrar     |  | 66. Signature of registrar    |  |
| 67. Name of informant      |  | 68. Address of informant     |  | 69. Signature of informant    |  |
| 70. Name of funeral home   |  | 71. Address of funeral home  |  | 72. Signature of funeral home |  |
| 73. Name of cemetery       |  | 74. Address of cemetery      |  | 75. Signature of cemetery     |  |
| 76. Name of undertaker     |  | 77. Address of undertaker    |  | 78. Signature of undertaker   |  |
| 79. Name of physician      |  | 80. Address of physician     |  | 81. Signature of physician    |  |
| 82. Name of registrar      |  | 83. Address of registrar     |  | 84. Signature of registrar    |  |
| 85. Name of informant      |  | 86. Address of informant     |  | 87. Signature of informant    |  |
| 88. Name of funeral home   |  | 89. Address of funeral home  |  | 90. Signature of funeral home |  |
| 91. Name of cemetery       |  | 92. Address of cemetery      |  | 93. Signature of cemetery     |  |
| 94. Name of undertaker     |  | 95. Address of undertaker    |  | 96. Signature of undertaker   |  |
| 97. Name of physician      |  | 98. Address of physician     |  | 99. Signature of physician    |  |
| 100. Name of registrar     |  | 101. Address of registrar    |  | 102. Signature of registrar   |  |

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BOSTON



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1381

01398

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                    |                                                                                                                                                             |                                                                                                                                             |                                                                                                                       |                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> <u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |                                                                                                                       |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>                                                                                                                                                                                                                                                                                                                                                                                 |                                    | c. LENGTH OF STAY IN 1b<br><u>DOA</u>                                                                                                                       |                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u>              |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sacred Heart Hospital</u>                                                                                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                             | d. STREET ADDRESS<br><u>104 "Mechanic Street</u>                                                                                            |                                                                                                                       | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <u>Willard 2 First Middle Lost</u><br><u>Lafayette Smith</u>                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>24</u> Year <u>1959</u>                                                                        |                                                                                                                       |                                                                                                   |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. COLOR OR RACE<br><u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 15, 1878</u>                                                                                                    |                                                                                                                       | 9. AGE (In years last birthday)<br><u>80 yrs.</u>                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Waiter (Retired)</u>                                                                                                                                                                                                                                                                                                                                                                |                                    |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Cumberland Country Barbadoes, West Indies</u>                                                       |                                                                                                                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>Unknown</u> ✓                                                  |
| 13. FATHER'S NAME<br><u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                                                                                                  |                                                                                                                       |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><u>no</u>                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>214-05-5863</u>                                                                                               |                                                                                                                       |                                                                                                   |
| 17. INFORMANT<br><u>John Trimble</u> Address <u>216 Carroll St.</u><br><u>Cumberland, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                                                                             |                                                                                                                                             |                                                                                                                       |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br><u>421.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Aortic Insufficiency</u><br>(a), stating the underlying cause lost. DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                    |                                                                                                                                                             |                                                                                                                                             |                                                                                                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 Days</u><br><u>?</u>                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                     |                                    |                                                                                                                                                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                |                                                                                                                       |                                                                                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>                                                                                                                                                                                                                                                                                                                                                                                                              |                                    | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                                   |                                                                                                                                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>20f. (City or town) (County) (State)</u> |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>             |                                    |                                                                                                                                                             |                                                                                                                                             |                                                                                                                       |                                                                                                   |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    |                                                                                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                             |                                                                                                                       |                                                                                                   |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                                                                                                             | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                         |                                                                                                                       |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                    |                                                                                                                                                             | 22b. DATE THEREOF<br><u>2/26/59</u>                                                                                                         |                                                                                                                       | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Memorial Park</u>                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John J. Hafer, Cumberland, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br>DATE <u>FEB 27 1959</u>                                                                                          |                                                                                                                       | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Harris</u>                                             |



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                                 |  |                                                                              |  |
|-------------------------------------------------|--|------------------------------------------------------------------------------|--|
| <p>1. Name of deceased: _____</p>               |  | <p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> |  |
| <p>3. Age: _____</p>                            |  | <p>4. Date of birth: _____</p>                                               |  |
| <p>5. Place of birth: _____</p>                 |  | <p>6. Usual residence: _____</p>                                             |  |
| <p>7. Date of death: _____</p>                  |  | <p>8. Time of death: _____</p>                                               |  |
| <p>9. Cause of death: _____</p>                 |  | <p>10. Manner of death: _____</p>                                            |  |
| <p>11. Signature of Medical Examiner: _____</p> |  | <p>12. Signature of Coroner: _____</p>                                       |  |
| <p>13. Signature of Registrar: _____</p>        |  | <p>14. Signature of Physician: _____</p>                                     |  |
| <p>15. Signature of Nurse: _____</p>            |  | <p>16. Signature of Family: _____</p>                                        |  |
| <p>17. Signature of Minister: _____</p>         |  | <p>18. Signature of Undertaker: _____</p>                                    |  |
| <p>19. Signature of Burial: _____</p>           |  | <p>20. Signature of Cremation: _____</p>                                     |  |
| <p>21. Signature of Other: _____</p>            |  | <p>22. Signature of Other: _____</p>                                         |  |
| <p>23. Signature of Other: _____</p>            |  | <p>24. Signature of Other: _____</p>                                         |  |
| <p>25. Signature of Other: _____</p>            |  | <p>26. Signature of Other: _____</p>                                         |  |
| <p>27. Signature of Other: _____</p>            |  | <p>28. Signature of Other: _____</p>                                         |  |
| <p>29. Signature of Other: _____</p>            |  | <p>30. Signature of Other: _____</p>                                         |  |
| <p>31. Signature of Other: _____</p>            |  | <p>32. Signature of Other: _____</p>                                         |  |
| <p>33. Signature of Other: _____</p>            |  | <p>34. Signature of Other: _____</p>                                         |  |
| <p>35. Signature of Other: _____</p>            |  | <p>36. Signature of Other: _____</p>                                         |  |
| <p>37. Signature of Other: _____</p>            |  | <p>38. Signature of Other: _____</p>                                         |  |
| <p>39. Signature of Other: _____</p>            |  | <p>40. Signature of Other: _____</p>                                         |  |
| <p>41. Signature of Other: _____</p>            |  | <p>42. Signature of Other: _____</p>                                         |  |
| <p>43. Signature of Other: _____</p>            |  | <p>44. Signature of Other: _____</p>                                         |  |
| <p>45. Signature of Other: _____</p>            |  | <p>46. Signature of Other: _____</p>                                         |  |
| <p>47. Signature of Other: _____</p>            |  | <p>48. Signature of Other: _____</p>                                         |  |
| <p>49. Signature of Other: _____</p>            |  | <p>50. Signature of Other: _____</p>                                         |  |
| <p>51. Signature of Other: _____</p>            |  | <p>52. Signature of Other: _____</p>                                         |  |
| <p>53. Signature of Other: _____</p>            |  | <p>54. Signature of Other: _____</p>                                         |  |
| <p>55. Signature of Other: _____</p>            |  | <p>56. Signature of Other: _____</p>                                         |  |
| <p>57. Signature of Other: _____</p>            |  | <p>58. Signature of Other: _____</p>                                         |  |
| <p>59. Signature of Other: _____</p>            |  | <p>60. Signature of Other: _____</p>                                         |  |
| <p>61. Signature of Other: _____</p>            |  | <p>62. Signature of Other: _____</p>                                         |  |
| <p>63. Signature of Other: _____</p>            |  | <p>64. Signature of Other: _____</p>                                         |  |
| <p>65. Signature of Other: _____</p>            |  | <p>66. Signature of Other: _____</p>                                         |  |
| <p>67. Signature of Other: _____</p>            |  | <p>68. Signature of Other: _____</p>                                         |  |
| <p>69. Signature of Other: _____</p>            |  | <p>70. Signature of Other: _____</p>                                         |  |
| <p>71. Signature of Other: _____</p>            |  | <p>72. Signature of Other: _____</p>                                         |  |
| <p>73. Signature of Other: _____</p>            |  | <p>74. Signature of Other: _____</p>                                         |  |
| <p>75. Signature of Other: _____</p>            |  | <p>76. Signature of Other: _____</p>                                         |  |
| <p>77. Signature of Other: _____</p>            |  | <p>78. Signature of Other: _____</p>                                         |  |
| <p>79. Signature of Other: _____</p>            |  | <p>80. Signature of Other: _____</p>                                         |  |
| <p>81. Signature of Other: _____</p>            |  | <p>82. Signature of Other: _____</p>                                         |  |
| <p>83. Signature of Other: _____</p>            |  | <p>84. Signature of Other: _____</p>                                         |  |
| <p>85. Signature of Other: _____</p>            |  | <p>86. Signature of Other: _____</p>                                         |  |
| <p>87. Signature of Other: _____</p>            |  | <p>88. Signature of Other: _____</p>                                         |  |
| <p>89. Signature of Other: _____</p>            |  | <p>90. Signature of Other: _____</p>                                         |  |
| <p>91. Signature of Other: _____</p>            |  | <p>92. Signature of Other: _____</p>                                         |  |
| <p>93. Signature of Other: _____</p>            |  | <p>94. Signature of Other: _____</p>                                         |  |
| <p>95. Signature of Other: _____</p>            |  | <p>96. Signature of Other: _____</p>                                         |  |
| <p>97. Signature of Other: _____</p>            |  | <p>98. Signature of Other: _____</p>                                         |  |
| <p>99. Signature of Other: _____</p>            |  | <p>100. Signature of Other: _____</p>                                        |  |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD., AND A COPY OF IT IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.



1382

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                              |                                    |                                                                                                                                                             |  |                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>                                                                                                                                                                                                                                                                          |  | MARYLAND                                                                                                     |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>                                        |  | b. COUNTY<br><b>ALLEGANY</b>                                                                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                      |  | c. LENGTH OF STAY IN 1b<br><b>7 Days</b>                                                                     |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>22. CUMBERLAND</b>                                                   |  |                                                                                                   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                               |  |                                                                                                              |                                    | d. STREET ADDRESS<br><b>104 Oak Street</b>                                                                                                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>WILLIAM</b>                                                                                                                                                                                                                                                                      |  |                                                                                                              | First Middle Last<br><b>JOSEPH</b> |                                                                                                                                                             |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Feb. 23, 19 59</b>                                       |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                      |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                             |                                    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 6, 1887</b>                                                           |  |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.                                                                                                                                                                                                                                                                          |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                    |                                    | IF UNDER 24 HRS.                                                                                                                                            |  |                                                                                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Master Mechanic</b>                                                                                                                                                                                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Undergarment</b>                                                     |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND, Cumberland</b>                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                     |  |
| 13. FATHER'S NAME<br><b>HARMON STEPPE</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                              |                                    | 14. MOTHER'S MAIDEN NAME<br><b>IDA GORDON</b>                                                                                                               |  |                                                                                                   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO.<br><b>214-05-6564</b>                                                                |                                    | 17. INFORMANT<br><b>PT'S CHART</b>                                                                                                                          |  |                                                                                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>c Infarction</b><br>DUE TO (c) |  |                                                                                                              |                                    |                                                                                                                                                             |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>                                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                          |  |                                                                                                              |                                    |                                                                                                                                                             |  |                                                                                                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |                                    |                                                                                                                                                             |  |                                                                                                   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>                                                                                                                                                                                                                                                      |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      |  | 20f. (City or town) (County) (State)                                                              |  |
| 21. I certify that I attended the deceased from <b>Feb. 18, 1959</b> to <b>Feb. 23, 1959</b> , that I last saw the deceased alive on <b>Feb. 23, 1959</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.                                                                      |  |                                                                                                              |                                    |                                                                                                                                                             |  |                                                                                                   |  |
| ACTUAL SIGNATURE<br><b>Clayton S. Durrett</b>                                                                                                                                                                                                                                                                              |  | M.D.<br><b>Cumberland Md</b>                                                                                 |                                    | ADDRESS (Street, city or town, state)<br><b>236 Virginia Ave.</b>                                                                                           |  | DATE SIGNED<br><b>2/23/59</b>                                                                     |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. W.E. Durrett</b>                                                                                                                                                                                                                                                                         |  |                                                                                                              |                                    |                                                                                                                                                             |  |                                                                                                   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                 |  | 22b. DATE THEREOF<br><b>2-26-59</b>                                                                          |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cem.</b>                                                                                                |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>                                                                                                                                                                                                                                                              |  |                                                                                                              |                                    | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                           |  | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 27 '59</b>                                                 |  |
|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                              |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                                                                                        |  |                                                                                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1988

1. NAME BORN

2. ADDRESS

3. CITY

4. STATE

5. ZIP

6. SEX

7. AGE

8. RACE

9. OCCUPATION

10. EDUCATION

11. RELIGION

12. MARRIAGE

13. DEATH

14. CAUSE

15. PLACE

16. TIME

17. SIGNATURE

18. DATE

19. SIGNATURE

20. DATE

21. SIGNATURE

22. DATE

23. SIGNATURE

24. DATE

25. SIGNATURE

26. DATE

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28. DATE

29. SIGNATURE

30. DATE

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32. DATE

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34. DATE

35. SIGNATURE

36. DATE

37. SIGNATURE

38. DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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1403

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01400

CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                          |                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                 |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>                                                                                                                                                                                                                                                       |                               | c. LENGTH OF STAY IN 1b <b>4 days</b>                                                                                                                    |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>                                                                                                                                                                                                                                                    |                               | d. STREET ADDRESS <b>52 Hill St.,</b>                                                                                                                    |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>                                                                                                                                                                                                                                                     |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                      |
| 3. NAME OF DECEASED (Type or print) <b>WILLIAM AUGUSTUS SWEITZER</b>                                                                                                                                                                                                                                                                                    |                               | 4. DATE OF DEATH <b>FEBRUARY 24, 19 59</b>                                                                                                               |                                      |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                      | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Feb. 8, 1892</b> |
| 9. AGE (In years less birthday) <b>67 yrs.</b>                                                                                                                                                                                                                                                                                                          |                               | IF UNDER 1 YEAR Months Days Hours Min.                                                                                                                   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Range operator</b>                                                                                                                                                                                                                                       |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Alleg. Ballistics</b>                                                                                               |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                               |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                               |                                      |
| 13. FATHER'S NAME <b>George Sweitzer</b>                                                                                                                                                                                                                                                                                                                |                               | 14. MOTHER'S MAIDEN NAME <b>Mary Donegan</b>                                                                                                             |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)                                                                                                                                                                                                                      |                               | 16. SOCIAL SECURITY NO. <b>214-01-6728</b>                                                                                                               |                                      |
| INFORMANT <b>Mrs. Bernadette Sweitzer, Frostburg,</b>                                                                                                                                                                                                                                                                                                   |                               | Address                                                                                                                                                  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b><br>260X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Diabetes</b><br>DUE TO (c) <b>Hypertension</b>                       |                               | INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b><br><b>4 mo</b><br><b>1 yr.</b>                                                                            |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                       |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19                                                                                                                                                                                                                                                                                             |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                  |                               | 20f. (City or town) (County) (State)                                                                                                                     |                                      |
| 21. I certify that I attended the deceased from <b>Feb 20, 1959</b> to <b>Feb 24, 1959</b> that I last saw the deceased alive on <b>Feb 24, 1959</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>1-25-59</b> |                               |                                                                                                                                                          |                                      |
| ACTUAL SIGNATURE <b>W O McLane</b>                                                                                                                                                                                                                                                                                                                      |                               | M.D. <b>W. O. McLane, M. D.</b>                                                                                                                          |                                      |
| PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>                                                                                                                                                                                                                                                                                                      |                               | Frostburg, Md.                                                                                                                                           |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                 |                               | 22b. DATE THEREOF <b>2-27-59</b>                                                                                                                         |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>                                                                                                                                                                                                                                                                                        |                               | 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>                                                                                      |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>                                                                                                                                                                                                                                                                                                    |                               | ADDRESS <b>Frostburg, Md.</b>                                                                                                                            |                                      |
| 24a. REC'D BY REGISTRAR <b>MAR 2 '59</b>                                                                                                                                                                                                                                                                                                                |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>                                                                                                         |                                      |



621

SEP 8 1971

*(continued)*

1995-1996

8998-10-15

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— 1997 —

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26



1383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01401

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |                                                                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                   |  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>                                                                                                                    |  |                                                                          |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>60 MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  |                                                                          |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RICHARD</b> Middle <b>L.</b> Last <b>TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                   |  | 4. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>25</b> Year <b>19 59</b>                                                                                   |  |                                                                          |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. COLOR OR RACE<br><b>WHITE</b>                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>DECEMBER 22, 1922</b>                             |  |
| 9. AGE (In years last birthday)<br><b>36</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ |  | IF UNDER 24 HRS.<br>Months _____ Days _____ Hours _____ Min. _____                                                                                          |  |                                                                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SUPER CONCRETE CO.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| 13. FATHER'S NAME<br><b>RICHARD L. TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>NORA M. TAYLOR</b>                                                                                                           |  |                                                                          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW 11</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                   |  | 16. SOCIAL SECURITY NO.<br><b>215-14-6083</b>                                                                                                               |  |                                                                          |  |
| 17. INFORMANT<br><b>WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL- CUMBERLAND, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Marsure Hemorrhage</b><br><b>581.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Esophageal Varicosities</b><br>DUE TO (c) <b>Portacaval Shunt by Scurin</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>21 hours</b>                                                                                                                     |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                         |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |  |                                                                          |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) _____ (County) _____ (State) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| 21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>59</b> , to <b>Feb</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 25</b> , 19 <b>59</b> , and that death occurred at <b>3:26 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>133 Va Ave Cumberland, Md</b> DATE SIGNED <b>2/26/59</b><br>ACTUAL SIGNATURE <b>J. O. G. Himmelwright M.D.</b><br>PHYSICIAN'S NAME (Type) <b>DR. O. G. HIMMELWRIGHT M.D.</b> <b>133 Va. Ave. Cumberland, Md. 2/26/59</b> |  |                                                                   |  |                                                                                                                                                             |  |                                                                          |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22b. DATE THEREOF                                                 |  | 22c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 22d. LOCATION (City, town, or county) (State)                            |  |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | <b>Feb. 27, 1959</b>                                              |  | <b>Hillcrest Burial Park</b>                                                                                                                                |  | <b>Cumberland, Maryland</b>                                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 2 '59</b>                                                                                                            |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kraus</b>                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1933

|                        |  |                        |  |                   |  |
|------------------------|--|------------------------|--|-------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE               |  |
| JAMES H. HARRIS        |  | Male                   |  | 45                |  |
| RESIDENCE              |  | PLACE OF DEATH         |  | DATE OF DEATH     |  |
| 1234 E. BALTIMORE ST.  |  | HOSPITAL               |  | JAN 15 1933       |  |
| CAUSE OF DEATH         |  | MANNER OF DEATH        |  | PLACE OF BURIAL   |  |
| HEART DISEASE          |  | NATURAL                |  | CATHOLIC CHURCH   |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | OFFICIAL SEAL     |  |
| J. H. HARRIS           |  | J. H. HARRIS           |  | [Seal]            |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE      |  | DATE OF SIGNATURE |  |
| JAN 15 1933            |  | JAN 15 1933            |  | JAN 15 1933       |  |



1408  
CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                                |                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                               |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                    |                                                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural 1 mile N. of Barton Md.</b>                                                                                                                                                                                                                                     |                                  | c. LENGTH OF STAY IN 1b<br><b>70 Yrs.</b>                                                                                                                      |                                                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION                                                                                                                                                                                                                                                                                 |                                  | /d. STREET ADDRESS                                                                                                                                             |                                                              |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                |                                                              |
| 3. NAME OF DECEASED (Type or print)<br><b>Sadie</b> First <b>Ann</b> Middle <b>Taylor</b> Last                                                                                                                                                                                                                                                               |                                  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>28</b> Year <b>19 59</b>                                                                                          |                                                              |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                      | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>May 15, 1885</b>                      |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.                                                                                                                                                                                                                                                                                                            |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                      | IF UNDER 24 HRS.                                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>                                                                                                                                                                                                                                               |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                                |                                                              |
| 13. FATHER'S NAME<br><b>James Fairgrieve</b>                                                                                                                                                                                                                                                                                                                 |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Amamada Warnick</b>                                                                                                             |                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                                                                                                                                                                                                                                                                              |                                  | 16. SOCIAL SECURITY NO.                                                                                                                                        |                                                              |
| 17. INFORMANT<br><b>Raymond Taylor</b>                                                                                                                                                                                                                                                                                                                       |                                  | Address<br><b>Barton, Md.</b>                                                                                                                                  |                                                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>443X</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO<br>(b) <b>Hypertensive Cardiovascular disease.</b><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                                                                                             |                                                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>                                                                                                                                                                                                             |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                              |                                                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                   |                                                              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                           |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                                              |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                       |                                  | 20f. (City or town) (County) (State)                                                                                                                           |                                                              |
| 21. I certify that I attended the deceased from <b>Feb. 23, 1959</b> , to <b>Feb. 28, 1959</b> , that I last saw the deceased alive on <b>Feb. 23, 1959</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.                                                                                                      |                                  |                                                                                                                                                                |                                                              |
| ACTUAL SIGNATURE<br><b>Mikio Kato</b>                                                                                                                                                                                                                                                                                                                        |                                  | ADDRESS (Street, city or town, state)<br><b>Donacoing, Md.</b>                                                                                                 |                                                              |
| PHYSICIAN'S NAME (Type)<br><b>MIKIO KATO</b>                                                                                                                                                                                                                                                                                                                 |                                  | DATE SIGNED<br><b>3/2/59</b>                                                                                                                                   |                                                              |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                   |                                  | 22b. DATE THEREOF<br><b>March 3, 1959</b>                                                                                                                      |                                                              |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill</b>                                                                                                                                                                                                                                                                                                     |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow Mills Maryland</b>                                                                                  |                                                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. J. Boral</b>                                                                                                                                                                                                                                                                                                       |                                  | ADDRESS<br><b>Westernport, Maryland</b>                                                                                                                        |                                                              |
| 24a. REC'D BY REGISTRAR<br><b>MAR 4 '59</b>                                                                                                                                                                                                                                                                                                                  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Kraus</b>                                                                                                          |                                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

The Day of

|                     |  |        |  |        |  |                  |  |                  |  |                   |  |                    |  |                   |  |                    |  |                            |  |                            |  |                          |  |
|---------------------|--|--------|--|--------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|-------------------|--|--------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of Deceased |  | 2. Sex |  | 3. Age |  | 4. Date of Birth |  | 5. Date of Death |  | 6. Place of Birth |  | 7. Usual Residence |  | 8. Cause of Death |  | 9. Manner of Death |  | 10. Signature of Physician |  | 11. Signature of Registrar |  | 12. Signature of Coroner |  |
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1384

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                           |  |                                                                                                                                                          |  |                                                                              |                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND                                                                                                                                                                                                                                                                                                         |  |                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |                                                                              |                                                                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                           |  |                                           |  | c. LENGTH OF STAY IN 1b<br><b>5 DAYS</b>                                                                                                                 |  |                                                                              |                                                                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>                                                                                                                                                                                                                             |  |                                           |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  |                                                                              |                                                                                       |
| 3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>S.</b> Last <b>Treiber</b>                                                                                                                                                                                                                                                                      |  |                                           |  | 4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>22</b> Year <b>19 59</b>                                                                                   |  |                                                                              |                                                                                       |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                         |  | 6. COLOR OR RACE<br><b>WHITE</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JUNE 3, 1875</b>                                      |                                                                                       |
| 9. AGE (In years last birthday) <b>83</b> yrs.                                                                                                                                                                                                                                                                                                                  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.                                                                                                                                         |  |                                                                              |                                                                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                 |  |                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND, Cumberland</b>     |                                                                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                   |  |                                           |  |                                                                                                                                                          |  |                                                                              |                                                                                       |
| 13. FATHER'S NAME<br><b>JOHN McNamara</b>                                                                                                                                                                                                                                                                                                                       |  |                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE DOHENY</b>                                                                                                      |  |                                                                              |                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)                                                                                                                                                                                                                                            |  |                                           |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                   |  | 17. INFORMANT<br><b>Mrs. Eleanor Fossett</b> Address <b>Cumberland, Md.</b>  |                                                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Surgical Shock</b><br><b>158x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal obstruction</b><br>DUE TO (c) <b>Carcinomatous peritoneal.</b> |  |                                           |  |                                                                                                                                                          |  |                                                                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b><br><b>2 wks.</b><br><b>3-4 mo.</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                               |  |                                           |  |                                                                                                                                                          |  |                                                                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  |                                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |  |                                                                              |                                                                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                              |  |                                           |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |                                                                                       |
| 20f. (City or town) (County) (State)                                                                                                                                                                                                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  |                                                                              |                                                                                       |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased olive on _____, 19____, and that death occurred at <b>11:16 A.M.</b> , from the causes and on the date stated above.                                                                                                                              |  |                                           |  |                                                                                                                                                          |  |                                                                              |                                                                                       |
| ACTUAL SIGNATURE <b>A. J. MIRKIN</b>                                                                                                                                                                                                                                                                                                                            |  |                                           |  | ADDRESS (Street, city or town, state) <b>115 So. Centre St. Cumberland</b> DATE SIGNED <b>2/27/59</b>                                                    |  |                                                                              |                                                                                       |
| PHYSICIAN'S NAME (Type) <b>A. J. MIRKIN</b>                                                                                                                                                                                                                                                                                                                     |  |                                           |  |                                                                                                                                                          |  |                                                                              |                                                                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 22b. DATE THEREOF<br><b>2/25/59</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cem.</b>                                                                                          |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |                                                                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>                                                                                                                                                                                                                                                                       |  |                                           |  | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 25 59</b>                                                                                                         |  | 24b. REGISTRAR'S SIGNATURE<br><b>Clifford S. Howard</b>                      |                                                                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1952

|                  |  |                |  |                  |  |                  |  |                 |  |                 |  |
|------------------|--|----------------|--|------------------|--|------------------|--|-----------------|--|-----------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX              |  | RACE             |  | DATE OF BIRTH   |  | PLACE OF BIRTH  |  |
| JAMES H. HARRIS  |  | 65             |  | M                |  | W                |  | JAN 15 1887     |  | BALTIMORE, MD.  |  |
| RESIDENCE        |  | DATE OF DEATH  |  | TIME OF DEATH    |  | CAUSE OF DEATH   |  | MANNER OF DEATH |  | PLACE OF DEATH  |  |
| 1000 N. E. ST.   |  | JAN 20 1952    |  | 10:30 AM         |  | HEART DISEASE    |  | NATURAL         |  | HOME            |  |
| OCCUPATION       |  | EDUCATION      |  | MARRIAGE         |  | PREVIOUS ILLNESS |  | TREATMENT       |  | BURIAL          |  |
| RETIRED          |  | HIGH SCHOOL    |  | MARRIED          |  | NONE             |  | NONE            |  | CATHOLIC        |  |
| FATHER'S NAME    |  | MOTHER'S NAME  |  | DATE OF MARRIAGE |  | DATE OF DEATH    |  | DATE OF BURIAL  |  | PLACE OF BURIAL |  |
| JAMES H. HARRIS  |  | MARY H. HARRIS |  | JAN 15 1910      |  | JAN 20 1952      |  | JAN 20 1952     |  | CATHOLIC        |  |
| DATE OF DEATH    |  | TIME OF DEATH  |  | CAUSE OF DEATH   |  | MANNER OF DEATH  |  | PLACE OF DEATH  |  | PLACE OF BURIAL |  |
| JAN 20 1952      |  | 10:30 AM       |  | HEART DISEASE    |  | NATURAL          |  | HOME            |  | CATHOLIC        |  |
| OCCUPATION       |  | EDUCATION      |  | MARRIAGE         |  | PREVIOUS ILLNESS |  | TREATMENT       |  | BURIAL          |  |
| RETIRED          |  | HIGH SCHOOL    |  | MARRIED          |  | NONE             |  | NONE            |  | CATHOLIC        |  |
| FATHER'S NAME    |  | MOTHER'S NAME  |  | DATE OF MARRIAGE |  | DATE OF DEATH    |  | DATE OF BURIAL  |  | PLACE OF BURIAL |  |
| JAMES H. HARRIS  |  | MARY H. HARRIS |  | JAN 15 1910      |  | JAN 20 1952      |  | JAN 20 1952     |  | CATHOLIC        |  |



1385

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                          |                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |                                                                                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>                                                                                                                 |                                                                                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>E.</b> Last <b>VAN NOY</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 4. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>28</b> Year <b>19 59</b>                                                                                |                                                                                              |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. COLOR OR RACE<br><b>WHITE</b>                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCTOBER 4, 1910</b>                                                   |
| 9. AGE (In years last birthday)<br><b>48 yrs.</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Service station attendant</b>                           | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>                            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 13. FATHER'S NAME<br><b>WILLIAM J. VAN NOY</b>                                                                                                           |                                                                                              |
| 14. MOTHER'S MAIDEN NAME<br><b>COCOA BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                          |                                                                                              |
| 16. SOCIAL SECURITY NO.<br><b>213-24-6536</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 17. INFORMANT<br><b>WARWICK &amp; MEMORIAL AVE. MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>                                                                  |                                                                                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br><b>581.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                                                                                           |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><b>Since July '57</b>                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                   | 20f. (City or town) (County) (State)                                                         |
| 21. I certify that I attended the deceased from <b>7-29-59</b> to <b>2-28-1959</b> , that I last saw the deceased alive on <b>2-28-1959</b> , and that death occurred at <b>10:55 P.M.</b> , from the causes and on the date stated above.                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                          |                                                                                              |
| ACTUAL SIGNATURE<br><b>W. J. Williams</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | ADDRESS (Street, city or town, state)<br><b>Cumberland Md</b>                                                                                            |                                                                                              |
| PHYSICIAN'S NAME (Type)<br><b>DR. W. F. WILLIAMS</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | DATE SIGNED<br><b>3-2-59</b>                                                                                                                             |                                                                                              |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                              | 22b. DATE THEREOF<br><b>3/3/59</b>                                                                        | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Cemetery</b>                                                                                         | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md</b>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Lee Silcox</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                        |                                                                                              |
| 24a. REC'D BY REGISTRAR<br><b>MAR 4 '59</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>                                                                                                    |                                                                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01405

Reg. Dist. No.

1386

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>                                                                                                                                                                                                                                                                                                            |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b> |  | c. LENGTH OF STAY IN IB<br><b>14 DAYS</b>                                                                                                                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>Washington</b>                                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HANCOCK, MARYLAND</b> |  | d. STREET ADDRESS<br><b>21X-2</b>                                                   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                      |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>MARY</b>                                                                                                                                                                                                                                                                                                           |  | First<br><b>MARY</b>                                                                                  |  | Middle<br><b>E</b>                                                                                                                                          |  | Last<br><b>WATSON</b>                                                                                                |  | 4. DATE OF DEATH<br>Month<br><b>FEBRUARY</b>                                    |  | Day<br><b>10</b>                                                                                             |  | Year<br><b>1959</b>                                                                 |  |                                                                                                   |  |                                                      |  |  |  |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                      |  | 6. COLOR OR RACE<br><b>WHITE</b>                                                                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>NOV. 6, 1877</b>                                                                              |  | 9. AGE (In years last birthday)<br><b>81</b> yrs.                               |  | IF UNDER 1 YEAR<br>Months<br><b>8</b>                                                                        |  | Days<br><b>10</b>                                                                   |  | IF UNDER 24 HRS.<br>Hours<br><b>19</b>                                                            |  |                                                      |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                              |  |                                                                                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Same</b>                                                                                                            |  |                                                                                                                      |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNA</b>                       |  |                                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |                                                                                                   |  |                                                      |  |  |  |
| 13. FATHER'S NAME<br><b>MICHAEL CRAWFORD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH J. SMITH</b>                           |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                              |  |                                                                                                       |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |  |                                                                                                                      |  | 17. INFORMANT<br>Address<br><b>Mrs James C Shhriver Penna. Ave. Hancock Md.</b> |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive arterio Sclerosis</b><br><b>442X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio vascular renodis.</b> DUE TO<br>(c) <b>1951</b> |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  | INTERVAL BETWEEN ONSET AND DEATH                                                    |  |                                                                                                   |  |                                                      |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                          |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  |                                                                                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                       |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |  |                                                                                                                      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  |                                                                                                              |  | 20f. (City or town) (County) (State)                                                |  |                                                                                                   |  |                                                      |  |  |  |
| 21. I certify that I attended the deceased from <b>1-27, 1959</b> , to <b>2-10-1959</b> , that I last saw the deceased alive on <b>2-9-1959</b> , and that death occurred at <b>3:05A M.</b> from the causes and on the date stated above.                                                                                                                   |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| ACTUAL SIGNATURE<br><b>W.F. Williams</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                       |  | M.D.<br><b>Cumberland Md</b>                                                                                                                                |  |                                                                                                                      |  | ADDRESS (Street, city or town, state)<br><b>Little Orleans Allegany Md.</b>     |  |                                                                                                              |  | DATE SIGNED<br><b>2-10-59</b>                                                       |  |                                                                                                   |  |                                                      |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>W.F. WILLIAMS</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  |                                                                                 |  |                                                                                                              |  |                                                                                     |  |                                                                                                   |  |                                                      |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  | 22b. DATE THEREOF<br><b>2.12.59</b>                                                                                                                         |  |                                                                                                                      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Piney Plains Methodist</b>             |  |                                                                                                              |  | 22d. LOCATION (City, town, or county) (State)<br><b>Little Orleans Allegany Md.</b> |  |                                                                                                   |  |                                                      |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Honour J. Shore Hancock Md</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                      |  | ADDRESS<br><b>Hancock Md</b>                                                    |  |                                                                                                              |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 16 '59</b>                                |  |                                                                                                   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1958

NAME OF DECEASED: WILLIAM J. WATSON  
 SEX: MALE AGE: 68 YEARS  
 DATE OF BIRTH: 1912  
 PLACE OF BIRTH: NEW YORK, N.Y.  
 OCCUPATION: RETIRED  
 MARITAL STATUS: MARRIED  
 DECEASED AT: HOME  
 DATE OF DEATH: 10/15/58  
 TIME OF DEATH: 10:30 AM  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: 1234 E. STREET, BALTIMORE, MD  
 SIGNATURE OF DECEASED: \_\_\_\_\_  
 SIGNATURE OF WITNESSES: \_\_\_\_\_  
 SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
 SIGNATURE OF CORONER: \_\_\_\_\_

NAME OF PHYSICIAN: DR. J. H. SMITH  
 ADDRESS: 567 N. AVENUE, BALTIMORE, MD  
 NAME OF CORONER: JOHN D. JONES  
 ADDRESS: 101 N. STREET, BALTIMORE, MD  
 NAME OF REGISTRAR: MARY K. WHITE  
 ADDRESS: 234 E. STREET, BALTIMORE, MD  
 NAME OF FUNERAL HOME: JOHN'S FUNERAL HOME  
 ADDRESS: 456 N. AVENUE, BALTIMORE, MD  
 NAME OF BURIAL PLACE: CATHOLIC CEMETERY  
 ADDRESS: 789 E. STREET, BALTIMORE, MD  
 NAME OF MINISTER: FRANK L. GREEN  
 ADDRESS: 123 N. STREET, BALTIMORE, MD  
 NAME OF CHURCH: ST. MARY'S CHURCH  
 ADDRESS: 456 E. STREET, BALTIMORE, MD  
 NAME OF MINISTER: FRANK L. GREEN  
 ADDRESS: 123 N. STREET, BALTIMORE, MD  
 NAME OF CHURCH: ST. MARY'S CHURCH  
 ADDRESS: 456 E. STREET, BALTIMORE, MD



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01406

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                          |                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                                                                                                                                          |                                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                             | c. LENGTH OF STAY IN lb<br><b>Lifetime</b> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>22 Frostburg</b>                                                  |                                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VFW Home</b>                                                                                                                                                                                                                                                                                                                                                  |                                            | d. STREET ADDRESS<br><b>212 Center Street</b>                                                                                                            | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>ROSS</b> Last <b>WHETSTONE</b>                                                                                                                                                                                                                                                                                                                                              |                                            | 4. DATE OF DEATH<br>Month <b>Feb</b> Day <b>1</b> Year <b>1959</b>                                                                                       |                                                                                                   |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. COLOR OR RACE<br><b>W</b>               | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-28-1894</b>                                                              |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                |                                            | IF UNDER 1 YEAR<br>Months                                                                                                                                | IF UNDER 24 HRS.<br>Days Hours Min.                                                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>                                                                                                                                                                                                                                                                                                                                    |                                            | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>House painting</b>                                                                                               | 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg, Md.</b>                                |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                            | 13. FATHER'S NAME<br><b>Frank Whetstone</b>                                                                                                              |                                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mollie Streets</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                            | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                                                         |                                                                                                   |
| 16. SOCIAL SECURITY NO.<br><b>214-09-9379</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                            | 17. INFORMANT<br><b>Mrs. Vesta Davis</b>                                                                                                                 |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) <b>sudden</b><br>DUE TO<br>cause lost.                                                                                                                                                     |                                            | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>                                                                                                        |                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                |                                            |                                                                                                                                                          |                                                                                                   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                |                                            | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                        |                                                                                                   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                                                                                                                                                                                                     |                                            | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                    |                                                                                                   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                        |                                            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                   |                                                                                                   |
| 20f. (City or town)<br><b>Frostburg</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                                            | (County) (State)                                                                                                                                         |                                                                                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                            |                                                                                                                                                          |                                                                                                   |
| ACTUAL SIGNATURE<br><b>W O McLane</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                            | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                     |                                                                                                   |
| EXAMINER'S NAME (Type)<br><b>W O McLane M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                            | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                      |                                                                                                   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                      |                                            | DATE SIGNED<br><b>Feb 2/1959</b>                                                                                                                         |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                            | 22b. DATE THEREOF<br><b>2-4-59</b>                                                                                                                       |                                                                                                   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Accident Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                   |                                            | 22d. LOCATION (City, town, or county) (State)<br><b>Accident Md.</b>                                                                                     |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Burial H. Winters</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                            | 24a. REC'D BY REGISTRAR<br><b>23 E. Main, Frostburg, Md.</b>                                                                                             |                                                                                                   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                            | DATE <b>FEB 9 '59</b>                                                                                                                                    |                                                                                                   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1387

## CERTIFICATE OF DEATH

01407

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |          |                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |          |                                                                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gumderland</u>                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X Gumderland Rt. #5</u>                              |          |                                                                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Secred Heart Hospital</u>                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                              |          |                                                                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Annie</u> Middle <u>White</u> Last <u>White</u>                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>9</u> Year <u>19 59</u>                                                                        |          |                                                                                     |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                        | 6. COLOR OR RACE<br><u>White</u>                                                                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>77</u> yrs.                                                                                                          |          | 9. AGE (In years last birthday)<br><u>77</u> yrs.                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>                                                                                        |          | 11. BIRTHPLACE (State or foreign country)<br><u>Pa.</u>                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | 13. FATHER'S NAME<br><u>Jacob Dwire</u>                                                                                                     |          |                                                                                     |
| 14. MOTHER'S MAIDEN NAME<br><u>Catherine Crowell</u>                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                   |          |                                                                                     |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | 17. INFORMANT<br><u>Chart</u>                                                                                                               |          |                                                                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterosecleriosis</u> DUE TO (c) _____ |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |          | INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoporosis + Osteoarthritis</u>                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |          | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |                                                                                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                                                             |          |                                                                                     |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>                                                                                                                                                                                                                                                          | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town)                                                                                                                         | (County) | (State)                                                                             |
| 21. I certify that I attended the deceased from <u>7/8</u> , 19 <u>59</u> , to <u>7/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>59</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.                                                        |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |          |                                                                                     |
| ACTUAL SIGNATURE<br><u>Leo Loy</u> M.D.                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | DATE SIGNED<br><u>7/10/59</u>                                                                                                               |          |                                                                                     |
| PHYSICIAN'S NAME (Type)<br><u>Dr. Leo Loy</u>                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | <u>456 N Center Street</u>                                                                                                                  |          |                                                                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                     | 22b. DATE THEREOF<br><u>2/11/59</u>                                                                       | 22c. NAME OF CEMETERY OR CREMATORY<br><u>GRANTSVILLE</u>                                                                                                    | 22d. LOCATION (City, town, or county) (State)<br><u>GRANTSVILLE GARRETT Co MD</u>                                                           |          |                                                                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Don Newman, Grantsville, Md</u>                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             | 24a. REC'D BY REGISTRAR<br><u>DATE 1 3 '59</u>                                                                                              |          |                                                                                     |
| 24b. REGISTRAR'S SIGNATURE<br><u>Catharine E. Francis</u>                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                                                                                             |          |                                                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1957

11507

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

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OCCUPATION

RELIGION

DATE OF DEATH

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PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION



1388

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                             |                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Bedford</b> ✓            |                                                                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyndman Rural</b>                                                    |                                                                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                              |                                                                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George A.</b> Middle <b>Wilm</b> Last <b>elm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                           | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>15</b> Year <b>1959</b>                                                                                    |                                                                              |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 15, 1880</b>                                 |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                                                                                              |                                                                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant-Service Station operator</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hyndman, Pa. RD#1</b>                                                                                               |                                                                              |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                  |                                                                              |
| 13. FATHER'S NAME<br><b>George Wilhelm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                           | 14. MOTHER'S MAIDEN NAME<br><b>Clara Troutman</b>                                                                                                           |                                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           | 16. SOCIAL SECURITY NO.<br><b>Mrs. George Wilhelm, Hyndman, Pa. RD#1</b>                                                                                    |                                                                              |
| 17. INFORMANT<br><b>Mrs. George Wilhelm, Hyndman, Pa. RD#1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           | Address                                                                                                                                                     |                                                                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic arteriosclerotic cardiovascular disease</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic prostatitis with marked hypertrophy. Pyelitis and cystitis.</b> |                                           |                                                                                                                                                             |                                                                              |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                             |                                                                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                             |                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                                                              |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                           | 20f. (City or town) (County) (State)                                                                                                                        |                                                                              |
| 21. I certify that I attended the deceased from <b>Approx 1950</b> , 19____, to <b>Feb. 15</b> , 19____, that I last saw the deceased alive on <b>Feb. 15, 1959</b> , 19____, and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Hyndman Pa. 2/17/59</b>                                                                                                                                                                                                     |                                           |                                                                                                                                                             |                                                                              |
| ACTUAL SIGNATURE <b>John A. Topper</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                           | M.D. <b>Hyndman Pa.</b>                                                                                                                                     |                                                                              |
| PHYSICIAN'S NAME (Type) <b>John A. Topper, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                             |                                                                              |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 22b. DATE THEREOF<br><b>Feb. 18, 1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Park</b>                                                                                             | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md. RD 3</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harvey H. Laylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                           | 24a. REC'D BY REGISTRAR<br><b>FEB 19 59</b>                                                                                                                 |                                                                              |
| ADDRESS<br><b>Hyndman, Pa.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>                                                                                                        |                                                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10



1405  
CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                             |                                         |                                                                                                                                                          |                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND                                                                                                                                                                                                                                                                     |                                         | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                                                        |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>                                                                                                                                                                                                                        |                                         | c. LENGTH OF STAY IN 1b<br><b>2 days</b>                                                                                                                 |                                                                        |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miners Hospital</b>                                                                                                                                                                                                                      |                                         | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                        |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>WILSON</b> Last <b>WILSON</b>                                                                                                                                                                                                                         |                                         | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>12,</b> Year <b>19 59</b>                                                                                   |                                                                        |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE <b>white</b>           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 21, 1888</b>                               |
| 9. AGE (In years last birthday) <b>70</b>                                                                                                                                                                                                                                                                                   |                                         | 10. IF UNDER 1 YEAR Months Days Hours Min.                                                                                                               |                                                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired brick layer</b>                                                                                                                                                                                                   |                                         | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>M. W. Ward</b>                                                                                                   |                                                                        |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                |                                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                            |                                                                        |
| 13. FATHER'S NAME<br><b>James M. Wilson</b>                                                                                                                                                                                                                                                                                 |                                         | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Fuller</b>                                                                                                      |                                                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                   |                                         | 16. SOCIAL SECURITY NO.<br><b>213-09-6571</b>                                                                                                            |                                                                        |
| 17. INFORMANT<br><b>Mrs. Wm. Wilson, Frostburg, Md.</b>                                                                                                                                                                                                                                                                     |                                         | Address                                                                                                                                                  |                                                                        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arterio Sclerosis</b><br>DUE TO<br>(c) |                                         | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 Days</b><br><b>several years</b>                                                                                |                                                                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                           |                                         | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                      |                                                                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |                                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                             |                                                                        |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                          |                                         | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                |                                                                        |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                      |                                         | 20f. (City or town) (County) (State)                                                                                                                     |                                                                        |
| 21. I certify that I attended the deceased from <b>Feb 12, 1959</b> to <b>Feb 12, 1959</b> , that I last saw the deceased alive on <b>Feb 12, 1959</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.                                                                          |                                         |                                                                                                                                                          |                                                                        |
| ACTUAL SIGNATURE <b>W O McLane</b> M.D.                                                                                                                                                                                                                                                                                     |                                         | ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>Feb 13 1959</b>                                                  |                                                                        |
| PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>                                                                                                                                                                                                                                                                          |                                         | <b>Frostburg, Md.</b>                                                                                                                                    |                                                                        |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                  | 22b. DATE THEREOF<br><b>Feb. 14 '59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>                                                                                         | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst, Frostburg, Md.</b>                                                                                                                                                                                                                                                      |                                         | 24a. REC'D BY REGISTRAR<br><b>Feb 16 '59</b>                                                                                                             |                                                                        |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>                                                                                                                                                                                                                                                                        |                                         |                                                                                                                                                          |                                                                        |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15-0-57172, Mr. Wilson, Treasurer, 15.

*Journal of Management Inquiry* 18(6)

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## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                    |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |                                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                                                                                                                                                                                                                             |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                                       |                                                                                                   |
| c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b>                                                                                                                                                                                                                                                                                                                          |                                  | d. STREET ADDRESS<br><b>1 BEDFORD RD.</b>                                                                                                                   |                                                                                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>                                                                                                                                                                                                                                                      |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                                                   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MARTHA VIOLA WOLFORD</b>                                                                                                                                                                                                                                                                           |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>FEB. 11 19 59</b>                                                                                                  |                                                                                                   |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                           | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 4, 1898</b>                                                           |
| 9. AGE (In years last birthday) yrs.<br><b>60</b>                                                                                                                                                                                                                                                                                                                 |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                                                                                              |                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                                                                                         |                                                                                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>W.VA.</b>                                                                                                                                                                                                                                                                                                         |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                  |                                                                                                   |
| 13. FATHER'S NAME<br><b>FRANK HOWERY (DECEASED)</b>                                                                                                                                                                                                                                                                                                               |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MALINDA HOUDYSHELL</b>                                                                                                       |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                            |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                                      |                                                                                                   |
| 17. INFORMANT<br><b>PATIENT'S CHART</b>                                                                                                                                                                                                                                                                                                                           |                                  | Address                                                                                                                                                     |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO (c) <b>4-6 yrs.</b> |                                  |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary Artery Disease - Severe</b>                                                                                                                                                                                      |                                  |                                                                                                                                                             | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                                |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>                             |                                                                                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                            |                                  | 20f. (City or town) (County) (State)                                                                                                                        |                                                                                                   |
| 21. I certify that I attended the deceased from <b>2-4</b> 19 <b>58</b> , to <b>2-11</b> 19 <b>59</b> , that I last saw the deceased alive on <b>2-11</b> 19 <b>59</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                                           |                                  |                                                                                                                                                             |                                                                                                   |
| ACTUAL SIGNATURE <b>William P. James</b> M.D.                                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                                                                                   |
| PHYSICIAN'S NAME (Type) <b>William P. James, M.D.</b> <b>441 N. Center St., Cumberland, Md.</b>                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        |                                  | 22b. DATE THEREOF<br><b>2/13/59</b>                                                                                                                         |                                                                                                   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Park</b>                                                                                                                                                                                                                                                                                                   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                                                                                     |                                                                                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Lee Silcox</b>                                                                                                                                                                                                                                                                                                          |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 16 '59</b>                                                                                                           |                                                                                                   |
| ADDRESS<br><b>Cumberland, Md.</b>                                                                                                                                                                                                                                                                                                                                 |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hays</b>                                                                                                         |                                                                                                   |

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